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THE PUBLICATION DESCRIBES MASSACHUSETTS STATE PLANS TO AID THE MENTALLY RETARDED. AFTER A CAPSULE REPORT, DEFINITION OF TERMS, AND REVIEW OF PROCEDURES, MORE THAN 50 RECOMMENDATIONS FOR REORGANIZATION AND EXPANSION ARE PRESENTED. AREAS COVERED ARE--FACTS, ADMINISTRATION OF SERVICES, COMMUNITY SERVICES, RESIDENTIAL AND EDUCATIONAL PROGRAMS, VOCATIONAL TRAINING AND EMPLOYMENT, MANPOWER, RETARDATION AND THE LAW, PREVENTION OF RETARDATION, STIMULATION OF RESEARCH, PUBLIC AND PROFESSIONAL AWARENESS, AND FINANCING. APPENDIXES PROVIDE HISTORY AND STATISTICS FOR RETARDATION IN MASSACHUSETTS AND NAME PLANNING BOARD AND TASK FORCE MEMBERS. ADDITIONAL CHARTS, MAPS, AND TABLES ARE INCLUDED. (JD)

ED016330

MASSACHUSETTS PLANS FOR ITS RETARDED

A TEN YEAR PLAN

THE REPORT OF THE MASSACHUSETTS MENTAL RETARDATION PLANNING PROJECT

MASSACHUSETTS PLANS FOR ITS RETARDED

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

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The Report of the Massachusetts Mental Retardation Planning Project

The Planning Project is being conducted by The Medical Foundation, Inc., Boston, Massachusetts, under a contract with the Massachusetts Department of Mental Health.

The Project has been funded by grants-in-aid from the United States Public Health Service with matching funds from the Massachusetts Department of Mental Health.

MASSACHUSETTS MENTAL RETARDATION PLANNING PROJECT

29 COMMONWEALTH AVENUE
BOSTON, MASSACHUSETTS 02116

December 1, 1966

His Excellency John A. Volpe
Governor of the Commonwealth
State House
Boston, Massachusetts

Dear Governor Volpe:

We have the honor to submit herewith the report of the Massachusetts Mental Retardation Planning Project.

The late President John F. Kennedy provided the impetus for retardation planning. In his first year in office, President Kennedy called for " . . . a comprehensive and coordinated attack on the problem of mental retardation." As a result of his leadership and the recommendation of his Panel on Mental Retardation, the 88th Congress enacted the "Maternal and Child Health and Mental Retardation Planning Amendments of 1963" (P.L. 88-156), which provided grants to develop statewide plans for the retarded.

In March 1964, former Governor Endicott Peabody designated the Department of Mental Health as the state agency to administer the planning grant and carry out the purposes of P.L. 88-156, and established the Planning Board of the Massachusetts Mental Retardation Planning Project and appointed to it the commissioners of all relevant state agencies to assure an interdepartmental approach. You appointed, in addition to the commissioners, eleven leading citizens to serve on the Planning Board — the policy making body of the Planning Project.

The Planning Board has devoted the past two years to studying and evaluating the proposals and policy positions of the nine task forces of the project. Hundreds of concerned citizens from all parts of the Commonwealth contributed much time and energy to explore all aspects of the complex problem. Physicians, social scientists, educators, lawyers, psychologists, social workers, and numerous experts in the field of retardation responded enthusiastically to the challenge of formulating a comprehensive plan for the retarded.

Retardation is one of the Commonwealth's major problems. Approximately 165,000 Massachusetts citizens are retarded. To these individuals and their families, retardation represents financial hardship, emotional strain, problems of adjustment, schooling and vocation, and untold human anguish. To the Commonwealth, retardation represents the tremendous economic and social cost of wasting human resources.

This report does not presume to present definitive solutions to all the complex problems associated with retardation. It does offer a forceful and far reaching plan which can begin to bestow the full benefits of our society on the retarded.

Just as our late President John F. Kennedy inspired the nation to search for solutions to the problem of retardation, we in Massachusetts must lead the nation in translating goals and proposals into comprehensive programs which will actually benefit our handicapped citizens.

Respectfully submitted,

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ACKNOWLEDGMENTS

In acknowledging the participation and cooperation of all those who made the Massachusetts Mental Retardation Planning Project possible, I do so as Project Director, not as author of this report.

Hundreds of people participated with great vigor, enthusiasm and knowledge. Some of their names are included in the list of task force members. Others have helped as individuals and must go unidentified because to name some will only do a disservice to the many others whose names were not systematically recorded. As with everyone, except the staff, all gave without financial remuneration. They participated because of their interest in improving conditions and activities for retarded people.

Many of the services necessary for a comprehensive approach to retardation programs were, and still are, underdeveloped in Massachusetts. The expertise brought to the task by all participants, coupled with energy and dedication, has translated a difficult task into a promising and workable plan for the retarded.

Responsibility for policy decisions and recommendations which follow was that of the Planning Board, chaired ably by Alfred L. Frechette, M.D., Commissioner of Public Health for the Commonwealth. This Board exercised its responsibility in a serious and deliberative manner. Board members gave to the task many hours of their valuable and limited time. Working with them has been a most pleasant experience for me.

Three of the senior officials of the Department of Mental Health deserve special attention: Dr. Harry C. Solomon, Commissioner; Dr. Robert W. Hyde, Assistant Commissioner for Mental Retardation, and Dr. Lewis B. Klebanoff, Assistant to the Director of Mental Hygiene for Mental Retardation. Their energetic, concerned and effective guidance contributed immeasurably to the many and complex issues. To Dr. Solomon, a special plaudit is necessary, for he made it possible for The Medical Foundation to do this job.

The interdepartmental direction of the Project was facilitated by the participation of officials assigned to work with us by their respective commissioners. These appointees shared the daily problems with the staff. Their understanding, support and help in overcoming the countless small obstacles is sincerely appreciated. Their names are included on the page listing staff members.

Our Project was conducted during two different state administrations. Complete cooperation was received throughout from both.

The staff were tireless in their efforts. They believed in the cause and their work showed it. Edward Newman, who was responsible for day by day administration, did a superb job as did all of his colleagues. If authorship is to be distributed, the words are theirs although the ideas are shared by the many described above.

It is hoped that the U. S. Department of Health, Education and Welfare and the Congress, who made possible this Planning Project, will be satisfied with the results. The specific proposal for state retardation planning grants was made possible by the late President John F. Kennedy. The decision to make such funds available was a wise one. We hope our efforts were equal to the assignment.

In closing may I especially thank the Board of The Medical Foundation. The Board has encouraged and supported our efforts to contribute to the community while allowing the Board of the Planning Project to retain complete policy control over the planning efforts.

HAROLD W. DEMONE, JR.

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PRINCIPAL RECOMMENDATIONS

A comprehensive set of recommendations for solving and working toward the solution of problems facing the retarded in Massachusetts have been proposed. All require implementation. However, certain recommendations comprise an essential core around which almost all the other recommendations revolve. The Planning Board designates the following 15 as having the highest priority. Enactment of these recommendations are vital to the goals of providing comprehensive retardation services throughout the Commonwealth.

STATE COORDINATION

1. An Office of Retardation, responsible to the Governor, should be established to coordinate state action to combat retardation.

COMPREHENSIVE LOCAL PROGRAMS

2. Comprehensive retardation programs should be organized in each of the designated areas to allow for the development of a coordinated network of community retardation services. Retardation areas should correspond to newly designated mental health areas.

3. Comprehensive retardation programs should be accessible locally to retarded persons to enable their families to assume a major supporting role for providing continuity of care with the assistance of essential community services.

4. Effective and viable systems of citizen participation through membership on area boards and regional committees should be established to make services responsive to local needs and to promote an active partnership among private, community and state retardation efforts.

REORGANIZING RESIDENTIAL PROGRAMS

5. All future residential facilities should house no more than 500 retarded persons. Plans should be developed to reduce the capacity of existing institutions to this size.

6. Regional centers for the retarded (state residential schools) should be reorganized, eliminating overcrowding, while emphasizing decentralized living arrangements and providing individual attention to help each resident to function at his highest level.

7. Group homes and other community based living arrangements should be provided as alternatives to institutional placement for those needing some protective supervision, but not requiring placement at regional centers.
Every effort should be made to keep retarded persons in their homes and in their communities.

BROADENING THE SCOPE OF EDUCATIONAL PROGRAMS

8. Services for retarded children in public school systems should be expanded and further developed to include universal preschool programs, multidisciplinary evaluations at the beginning of formal schooling and the provision of vocational training, work experience and job placement, during the latter stages of formal schooling.

9. A substantial increase in educational services should be provided at the regional centers for the retarded for teaching academic, vocational and social skills to all residents. Particular attention should be given to the severely retarded and chronically ill who are confined to their wards and require "homebound" instruction.

EXPANDING VOCATIONAL TRAINING AND EMPLOYMENT

10. The Massachusetts Rehabilitation Commission should assume a major role in providing or securing vocational rehabilitation services for the retarded. To accomplish this end matching funds should be appropriated by the legislature to fully utilize federal monies authorized under the Vocational Rehabilitation Act Amendments of 1965.

MEETING PERSONNEL NEEDS

11. The Legislative Commission on Mental Retardation in collaboration with the proposed Office of Retardation and officials of state health, education and welfare agencies should undertake a study of grade and salary classifications and job descriptions of personnel working with retarded persons in all agencies of the Commonwealth.

CHANGING THE LAW

12. A comprehensive recodification of state statutes and regulations affecting the well being and protection of the retarded should be undertaken without delay. Special attention should be given to a comprehensive overhauling of Chapter 123 of the General Laws of the Commonwealth of Massachusetts.

PREVENTING RETARDATION

13. Programs aimed at improving prenatal and postnatal care, detecting inborn errors of metabolism, offering genetic counselling services, expanding immunization services, preventing toxic poisoning and reviewing child abuse laws should be expanded and developed to alleviate conditions which increase the risk of retardation. Other preventive approaches should include preschool enrichment programs for children in areas of high socioeconomic need which should be followed by supplementary and compensatory programs for pupils in the early primary grades.

INCREASING RESEARCH EFFORTS

14. Each state agency serving the retarded should support research in retardation by at least 4% of the agency's direct service expenditure for the retarded.

EXTENDING INFORMATION AND EDUCATION

15. A Communications and Education Unit should be established by the Commonwealth to fulfill a public and professional information and education function in support of the development and utilization of services for the retarded and their families.

CAPSULE REPORT

A STATEMENT OF PRINCIPLE

The needs of individuals who are retarded are, at a minimum, the needs of all individuals. Retarded persons are entitled to all the rights and privileges accorded every citizen, including equal protection under the law.

Intellectual, developmental and social handicaps associated with retardation place persons in this disabled group among the most vulnerable in the population.

Not all retarded persons reside in state or private institutions. More than 90% of the retarded live in the community. These individuals must rely upon local services to help them. Programs must be developed at the community level to aid retarded persons and their families to receive needed support and care.

All retarded persons should have the opportunity to develop to their maximum potential. Providing the means to achieve this goal is the responsibility of the entire society — the family, the community, the voluntary and the governmental agencies.

Services provided to the general population by the Commonwealth and by local communities should also be available to the retarded. In addition to generic services, various types of specialized services are necessary to overcome or alleviate the disabilities commonly associated with retardation.

Problems of the retarded are not, and can not be, the exclusive responsibility of any particular agency or any specific organization. Since a variety of services are necessary to respond to the total needs of the retarded and their families, programs must be coordinated to assure comprehensiveness and continuity.

A plan for statewide organization and community action has evolved from the deliberations of the Planning Board of the Massachusetts Mental Retardation Planning Project, the work of the various task forces, the information gathered at public hearings, through studies and through involvement with interested citizens from all walks of life.

AN INTERDEPARTMENTAL APPROACH

Almost $50 million was expended in 1965 by seven of the Commonwealth's health, education, welfare and correction agencies providing services to the state's retarded population. The very multiplicity of retardation programs and the numbers of different agencies responsible for serving the retarded makes the need for coordination imperative and urgent.

Current conditions only serve to enhance and document the need for new approaches:

- No plans exist for essential interdepartmental integration of retardation activities within the forthcoming community mental health programs.
- Over-all long range retardation planning has not been the responsibility of any single department or agency.
- No mechanism exists for the coordination of retardation inservice training programs.
- No communications apparatus exists for disseminating reliable up-to-date information.
- Research efforts go off in all directions.

An Office of Retardation, responsible to the Governor, should be established immediately. The Office should: develop, and keep current, a state plan to aid retarded persons; establish standards for services; provide liaison with the federal government; and assist all departments and other agencies and organizations to improve their programs and services for the retarded.

More than 50 of the recommendations approved by the Planning Board of the Massachusetts Mental Retardation Planning Project reflect the need for an interdepartmental planning agency. Explicitly, or implicitly, these proposals point out the necessity of interdepartmental coordination and cooperation. Some examples follow:

The proposed Office of Retardation will encourage retardation research by administering the state retardation research fund; by conducting symposia on retardation research and by assisting universities, medical schools and hospitals to obtain research funds.

To adequately train personnel for their new jobs, the Office of Retardation will work with various state departments to develop appropriate inservice training programs for all agencies serving the retarded and their families.

An Office of Retardation will play a large role in stimulating effective vocational services for the retarded by working with the Massachusetts Rehabilitation Commission, Department of Mental Health, Department of Education, and Division of Employment Security to determine the adequacy of existing services and the appropriate role for each agency. In addition, the Office will collaborate with the relevant agencies to assure that adequate supportive services are available to retarded clients in workshops.

Furthermore, the Office of Retardation will assemble and disseminate departmental rules and regulations relating to retardation; will prepare a manual outlining standards for facilities, for personnel and for licensing arrangements for retardation programs.

A number of studies and research projects have been recommended to be undertaken by an Office of Retardation. These include: a study of the feasibility of establishing a Division of Adult Guardianship; a legal study of the status of persons with multiple disorders; a comprehensive study of the civil rights of institutionalized retarded persons; a study to determine the feasibility of establishing research units at Dever, Belchertown and Hathorne state residential schools; and a study of the temporary certificate situation in regard to physicians and teachers.

Examples noted above represent a few proposed functions for an Office of Retardation. The Office will have a significant role in implementing all recommendations which call for interdepartmental collaboration and interagency coordination.

PUBLIC PROGRAMS FOR THE RETARDED

Estimates vary greatly as to the numbers of retarded persons residing in the Commonwealth. A statewide survey of approximately 600 agencies conducted by the Planning Project identified more than 35,000 retarded persons served by health, education and welfare agencies in the state.

Although this total represents only those presently identified, if the totals included those afflicted with milder forms, more than 165,000 individuals could be included in the retarded grouping.

Most of those persons identified as retarded, many with more severe forms of disability, received services through the Department of Mental Health. The Department serves more than 12,000 retarded persons in all its programs. Special class programs, in the public schools under the supervision of the Department of Education's Bureau of Special Education, reach about 12,000 school age children.

Through programs of Aid for Families with Dependent Children, Aid for the Disabled and Child Guardianship programs, the Department of Public Welfare serves more than 7,000 retarded individuals.

The Department of Public Health serves about 1,150 retarded in its maternal and child health and crippled children activities. In addition, phenylketonuria (PKU) detection programs screened 110,000 individuals last year.

Under new federal amendments, the Massachusetts Rehabilitation Commission will have major responsibility for the training and rehabilitation of the retarded. Correctional agencies also serve a considerable number of retarded individuals.

Public programs on behalf of the retarded have expanded considerably over the past decade. They will develop manyfold in the next decade. These existing programs must continue to expand. New programs must also be developed to benefit the many individuals afflicted with milder, but still debilitating forms of retardation.

To some extent the expanded programs will relieve the pressures from programs sponsored mainly by associations for retarded children, which do not have adequate financing to meet the demand for services.

Based upon studies of the programs of state agencies, the Planning Board of the Project strongly urges immediate implementation of high level administrative direction in each of the state departments. New executive positions should be established to work closely with staff members of the proposed Office of Retardation to enhance both intra and interdepartmental progress on behalf of the retarded.

ELEMENTS OF A COMMUNITY RETARDATION PROGRAM

To assure that services for the retarded are accessible locally, retardation programs should serve population areas of approximately 75,000 to 200,000 people. Under legislation recently enacted by the state legislature, local comprehensive retardation programs will be developed in each of approximately 37 areas throughout the Commonwealth. In each area, combined mental health-retardation boards, composed of representative officials and interested citizens, will guide the development of local programs for the retarded. Each area program should have its own unique character reflecting the special needs and resources of the area.

However, these boards and the staff assigned to them will need assistance in assuring that a total range of needed services evolve. Where services do not exist, they should be developed. When services are not readily available, they should be made more accessible. The Office of Retardation will be an important and welcome partner in assuring that area retardation programs throughout the Commonwealth develop an array of balanced and comprehensive services.

A community retardation program should include the following elements to assure comprehensiveness and continuity of care:

- Preventive, diagnostic and evaluative services.
- Treatment services.
- Training programs.
- Educational services.
- Personal care services.
- Prevocational and vocational services.
- Recreational and other leisure time services.
- Short and long term residential services.

BUILDING A RETARDATION PROGRAM

Even in those geographic areas where a substantial battery of services will be provided under one roof, it is essential to recognize the comprehensive nature of a total program for the retarded. An area program should not be limited to a local unit of a state department or to any other single public or voluntary agency or association. Programs should include all legitimate services, facilities and care givers, regardless of auspice.

Agencies should be flexible enough to accommodate a variety of problems. If one agency cannot extend the proper service, it should take the responsibility for follow up and referral to another community agency where the retarded person could secure the appropriate service.

Retarded individuals and their families should be able to look to a single, visible and accessible community agency where they can turn for continuing lifetime guidance and assistance.

As they are established in each area, retardation programs should provide diagnostic and counselling services.

Utilizing the experiences of the recently established comprehensive retardation centers in Worcester and Quincy, the Department of Mental Health is planning for the development of two new comprehensive mental health-retardation programs a year in addition to the major complex recently completed in Lowell and one under construction in Fall River. Supportive training, habilitation, parent counselling, day care and short term residential services should buttress diagnostic and evaluative services and extend these services further to all age groups.

A SOCIAL DEVELOPMENT APPROACH TO RESIDENTIAL PROGRAMS

Existing state institutional programs for the retarded are impoverished. They have easily recognizable shortcomings. They have deficiencies which should be eliminated.

Essentially, the problem of the state residential school is that care is provided on a nonindividualized basis. An overlarge mass production system provides adequate medical care, custody and security. Small group and individual relations, so vital for stimulating and reinforcing social growth potential, are missing.

As long as these institutions remain overcrowded and understaffed, no realistic alternative is possible. Resources for the direction and supervision of social and recreational programs appear woefully inadequate. No one high level administrative person has the specific responsibility for seeing that the residents of the state schools have adequate social programs.

Residential schools must be helped to provide:

- An emphasis upon social development.
- An individual and small group approach.
- Meaningful links with the community.

A variety of resources will be necessary to implement these goals. These resources include facilities, changed spatial arrangements, additional and changed distribution of personnel and additional and changed emphases in programs.

Action outlined by the Planning Project focuses upon changes in the existing residential and in proposed new residential facilities, including community alternatives to institutionalization.

Existing state schools should exhibit an expanded commitment to community oriented services including consultation, day care and vocational training. These commitments should be reflected by changing the name from state residential schools to regional centers for the retarded.

At present, each residential school for the retarded accommodates between 1,200 and 2,200 residents. Modern practices throughout this nation and others point to the benefit derived from smaller, more manageable living arrangements. Nevertheless, overcrowding and pressure for admission to residential centers makes it impracticable and grossly uneconomical to dismantle the multimillion dollar investments represented by the existing institutions.

A functional unit plan to reduce the number of residents cared for by direct patient care personnel and other professional personnel has been detailed. An essential objective of the functional unit plan aims to develop semiautonomous communities within large multifaceted institutions, varied for different age groups and for the extent of disabilities. Each functional unit will be broken down to smaller, more livable sleeping and living accommodations.

Any new building additions at the existing institutions should be for replacement purposes only. Construction plans should be guided by the emphasis on decentralized, small unit living arrangements and a reduction in the population of the entire institution.

Two primarily medical units should be established: a hospital unit and an infirmary unit. Three primarily nonmedical units should be established: a children's unit, an adolescent unit and an adult unit.

Effective decentralization will develop through the division of the institution into primarily nonmedical and medical sections and through the acquisition of three highly qualified assistant superintendents: one in the area of social development, education and training; another for medical services; and the third in charge of management. Following this, the now overly large institution should be divided into the proposed functional units. New positions of directors of functional units should be established to supervise and coordinate an integrated program for developmental needs of residents in the functional units.

New, smaller residential centers will open in Massachusetts in the near future; others are in the planning stage.

Present residential accommodations, together with the planned facilities in Boston, Worcester and Springfield, will barely meet projected residential needs in the next decade.

For many years in many states (including Massachusetts), too many children have been institutionalized in state residential schools because of the lack of available group homes and other community residential alternatives. In addition, administrative and staffing difficulties deter securing placements. Efforts should be accelerated to expand joint foster care programs between the Department of Mental Health and the Division of Child Guardianship.

Unless additional places are created in the community for those needing protective residential care, many retarded persons may be doomed to a lifetime in an institution. By overcrowding the state schools, the more handicapped may be deprived of adequate and appropriate care.

The Department of Mental Health should investigate the development of community homes for independent living for adult retardates. Other living arrangements which should be considered include halfway houses to complete the transition from institution to semiindependent living or adult "colonies" stressing maximum self help and a long term contribution to a sheltered community.

STRIDES IN SPECIAL EDUCATION

Considerable progress has been made in the past decade in the education of retarded children. Nevertheless, the responsibility of providing adequate educational services has only begun to be met.

Discovering existing or potential learning disorders as early as possible is a major issue for consideration. Help in the early years may have great influence upon a child's ultimate development.

Comprehensive assessment of the potential of young students is required. A proposed evaluation process includes the collaboration of educators, psychologists, physicians and social workers and others qualified to participate in a comprehensive team effort.

Special class kindergartens should be established and preschool clinics expanded. Additionally, day care programs should be established in each service area for severely retarded children who do not qualify for special classes.

All school systems should provide special class services for retarded children. Towns with less than five children identified as retarded are not required to provide special classes, although they are required by law to provide education for every child who can be educated. Sixty towns and school systems still do not provide special classes. This inequity should be eliminated.

Effective remedial techniques, classroom procedures, methods of instruction and appropriate curricula for retarded children should be developed. At the present time little objective evidence exists about the relative merits of alternative educational techniques and methods.

During the latter stages of schooling, the type of vocational preparation given to the retarded pupil could spell the differ-

ence between his chances for independent or semiindependent functioning and his need for a more dependent adulthood. Vocational training, work experience and job training programs must be developed further to help the retarded pupil face the future with greater confidence.

LEGAL SAFEGUARDS FOR THE RETARDED

An effective measure of a society's humanity is the extent to which it protects the individual dignity of its members and the extent to which it provides legal safeguards for the care and protection of its vulnerable members. In the last analysis, the law is the final repository of the major social decisions which shape and influence the lives of all persons. Failure to protect the dignity of any one segment of a population reduces the dignity of all.

Massachusetts has a history of a proliferation of programs for the retarded. However, the legal framework within which the programs rest leave the retarded deprived of one of the basic tenets of our society — equal protection under the law.

As a consequence of concerted efforts by the Special Legislative Commission on Mental Health, its legal staff and the Retardation Planning Project, a complete overhaul of legal provisions effecting the retarded is now underway in Massachusetts. Legal problems receiving the greatest emphasis are the appointment of guardians, determination of competency, definitions of retardation, legal standards for diagnosis and evaluation, periodic judicial review of all institutionalized persons and the provision for independent legal assistance to persons in state facilities.

As a result of this undertaking, Massachusetts' laws for the retarded will receive the first general review since laws for the retarded first appeared in Massachusetts' statutes more than a century ago.

PREVENTION

Many strides are still to be made in discovering the underlying causes of conditions which increase the risk of retardation. Yet, within the limits of our current knowledge, considerable progress is possible. Within the limits of our current technology, this progress can be translated into immediate action.

Specific recommendations in the biomedical area addressed to relevant agencies, the legislature and professional organizations include:

- Improving prenatal and postnatal care.
- Detecting inborn errors of metabolism.
- Offering genetic counselling services.
- Expanding immunization programs.
- Reviewing child abuse laws.
- Preventing toxic poisoning.

Emphasis must also be directed toward early intervention by health, welfare and education agencies to prevent or reduce the dire consequences of impoverished social conditions. Poor social conditions can have disastrous effects from the moment of conception and are considered to induce progressively more deleterious effects.

Preschool enrichment programs for children in areas of high socioeconomic need should be expanded and improved. Supplemental and compensatory programs for children in the early primary grades are also proposed.

Health, education and welfare agencies respond to incentives for improving their services in much the same way as individuals respond to support and encouragement. Established health, education and welfare agencies provide many of the human services to the disadvantaged in the Commonwealth. These agencies should be encouraged to extend their efforts to populations of highest risk and greatest need.

In particular, schools and hospitals should develop extended demonstrations to experiment with methods for reducing service gaps and fragmentation. Often, service defects especially effect the lower income clients and are potentially costly in human and economic terms.

MANPOWER AND TRAINING

All programs serving the retarded have experienced difficulties in attracting and holding personnel.

Reacting to the stimulus of local, state and federal developments in service programs, many disciplines are in the process of reevaluating their potential contribution to the retarded. To capitalize upon this new interest will be a formidable task since all service fields have tremendous staff shortages.

To effectively compete for personnel, the retardation field must work strenuously to fulfill three major criteria: challenge, salary and status. Currently, positions for serving the retarded rank low on all three criteria. Attention being focused on prevention and on the problem of the culturally deprived has vastly extended the scope of previous manpower requirements.

Consideration must be given to the upgrading of skills on existing jobs through integrated and joint inservice training programs and to the continuation of formal education through salary incentives and paid educational leave. Grade and salary classifications should be reevaluated in the light of new goals and required qualifications.

Great promise appears to rest in untapped manpower resources, the use of part time personnel and graduates from junior and community colleges.

The training base must be broadened considerably. Student fellowships, the training of additional faculty and the introduction of specific university training programs in retardation are only a few suggestions.

Manpower requirements and alternatives deserve careful attention and study by the legislature and executive departments of the Commonwealth. The Legislative Commission on Mental Retardation, in collaboration with the proposed Office of Retardation and officials of state health, education and welfare agencies should undertake a comprehensive study of grades, job functions and work incentives for personnel working with the retarded in all agencies of the Commonwealth.

ACTION ON THE TOTAL PLAN BY 1976

The Planning Board of the Mental Retardation Planning Project recognizes the keen and legitimate competition for limited public funds in health, education and welfare. At the same time, the Planning Board realizes the seriousness of the problem of retardation. Opportunities for increasing the

productivity and well being of such a formidable number of Massachusetts' citizens necessitates a substantial commitment of continued and expanded assistance.

In the decade ahead, the Commonwealth must lead the way in providing services to its retarded citizens. Voluntary efforts alone, although valiant and generous, cannot provide the necessary resources. Undoubtedly, the federal government will expand its assistance to the states for retardation programs. Yet, for the foreseeable future, federal resources will be available in limited amounts in proportion to total state needs and primarily for construction and to some extent for training purposes. Clearly, the major share of the financial responsibility must be borne by the Commonwealth.

Expenditures for the recommended programs fall into two broad categories: immediate and urgent programs necessary to catch up with accumulated lags and program deficits over the past few years; and the entire program to be completed by 1976 (see Table 1).

The Commonwealth has made large strides toward expanding its programs for the retarded since World War II, in large part through efforts of the Legislative Commission on Retarded Children. However, with the population increasing by approximately one-third each decade, the state has scarcely kept pace with the challenge of providing adequate programs for the retarded. Also, a substantial proportion of programs, especially those under the auspices of the Department of Mental Health, have been hard pressed to keep pace with needs since the proportion of the state budget allocated to the Department has been declining in recent years.

In addition to an amount of almost $50 million currently expended for retardation programs:

- $13,784,244 will be needed annually by 1968 for immediate and urgent needs.
- $45,225,000 will be needed annually by 1976 to implement the total program recommended by this comprehensive plan.

TABLE 1

ANNUAL STATE EXPENDITURE FOR RECOMMENDED PROGRAMS

	"Catch Up" by Fiscal 1968	*Entire Program by Fiscal 1976*
Administration	$ 147,000	$ 147,000
Community services	1,500,000	18,500,000
Residential programs	2,954,724	10,000,000
Educational programs	5,000,000*	12,500,000*
Vocational programs	250,000	to be determined
Legal services	125,000	140,500
Prevention	307,500	692,500
Research	1,000,000	3,000,000
Communications unit	—	245,000
	$13,784,224	$45,225,000

*Includes local public matched funds (Local Aid Fund).

Many of the recommended increases include the addition of new and upgraded personnel — the essential skilled manpower necessary for providing effective human services to this disabled population. Yet, it must be kept in mind that new positions and new services cannot be efficiently utilized without a complete and detailed review of existing manpower resources.

Included among the urgent programs recommended for fiscal 1968 are the establishment of the Office of Retardation and top level executives recommended for various other state agencies.

Three area comprehensive community retardation programs should be instituted during the next two years.

In each ensuing year three additional community retardation programs should be instituted until all 37 areas are covered.

Immediate residential program needs include the employment of initial personnel who will begin implementing plans for reorganization of regional centers and the approval by the legislature of personnel recommended by the Legislative Commission in December 1965. Public education will require additional funds to acquire additional teachers to conform to proposed teacher/pupil ratio standards.

A modest increase in public health preventive programs could spell the difference between assuring the development of self sustaining adults rather than the possible lifetime institutionalization of an individual.

Even during the short lifetime of the PKU screening programs, at least 36 children have been discovered and appropriately treated. At an estimated $130,000 per individual for lifetime institutionalization, approximately $4.5 million, has been saved on this one preventive program alone.

Programs of legal protection, research and vocational training are urgently needed. In the latter case, the Commonwealth should immediately match funds made available under the 1965 Amendments to the Vocational Rehabilitation Act to increase its commitment to the rehabilitation of young adult and adult retardates. A detailed study and 10 year projection of vocational rehabilitation needs will be completed by 1968 by the Massachusetts Vocational Rehabilitation Planning Commission.

The total program recommended by the Planning Project will cost the state approximately $95 million (at 1965 prices) by fiscal 1976; an increase of 92% over current expenditures.

This sound investment will unquestionably provide benefits to the retarded, their families and the entire population far exceeding the expenditures involved.

For this investment the Commonwealth will have:

- 37 comprehensive retardation programs throughout the state.
- Accessible local services with no waiting lists.
- Coordinated statewide administration.
- Expanded educational and vocational opportunities.
- Equal rights for the retarded under the law.
- Increased safeguards to prevent retardation.
- Stepped up research programs to develop new knowledge.
- Accurate and reliable public and professional informational and educational activities.

CONTINUED PLANNING AND IMPLEMENTATION

Publication of this report does not mark the end of the activities of the Mental Retardation Planning Project. Staff of the project will be active during the coming year to assist public and voluntary agencies, the legislature and concerned professional and voluntary groups in implementing many of

the vital Project proposals. Project staff will concentrate upon establishing the basic requirements — administrative, legal and key personnel — to make possible the development of comprehensive retardation programs throughout Massachusetts.

PROSPECTS FOR PROGRESS

An imposing task lies ahead. However, a review of the succession of events in the nation and in Massachusetts, particularly in the past decade, point to clearly discernable marks of progress. The report of the Planning Board of the Massachusetts Mental Retardation Planning Project provides the Commonwealth with an opportunity for taking stock and for emphasizing promising directions during the next decade. In the process, the urgency of the steps which must be taken tomorrow stand out vividly.

The legislature, the state executive departments, the universities and other public and voluntary organizations must be alerted to their tasks and opportunities to serve this large, vulnerable segment of our population. Highlighting the importance of the need for greater public and professional awareness, a model for a state level information and education unit to serve as a central vehicle for the dissemination of accurate and reliable information has been developed. If progress is to be made toward achieving the goals of prevention and the more effective provision of services to the retarded, the Commonwealth must commit each of its agencies serving the retarded to ongoing research efforts to buttress the provision of client services.

Important legislation emanating from the Special Commission on Mental Retardation has provided the impetus for expanded programs for the retarded in the Departments of Education and Mental Health.

If Massachusetts is to take seriously its mandate for an effective interdepartmental attack on retardation, the Commonwealth must develop the administrative machinery for program development in all health and welfare agencies. An interdepartmental Office of Retardation will spur efforts toward workable collaborative and cooperative arrangements.

Residential programs, especially for the more severely handicapped, will still be needed in the foreseeable future. However, efforts are underway which will further humanize existing institutions and provide for smaller and more flexible alternatives to institutionalization in the coming years.

Prospects for effective comprehensive community programs for the retarded are brighter than at any time in the history of the Commonwealth.

The retarded have many friends in Massachusetts including those who participate so diligently in the work of associations for retarded children.

Continued diligence and compassionate concern for the retarded by all interested citizens will have significant consequences for the implementation of the comprehensive array of services proposed in this report.

RETARDATION DEFINED

DEVELOPMENTAL CHARACTERISTICS, POTENTIAL FOR EDUCATION AND TRAINING, AND SOCIAL AND VOCATIONAL ADEQUACY AT FOUR LEVELS OF RETARDATION

Level	*Preschool Age 0–5, Maturation and Development*	*School Age 6–21, Training and Education*	*Adult 21 and Over, Social and Vocational Adequacy*
Profound	Gross retardation; minimal capacity for functioning in sensorimotor areas; needs nursing care.	Obvious delays in all areas of development; shows basic emotional responses; may respond to skillful training in use of legs, hands, and jaws; needs close supervision.	May walk, need nursing care, have primitive speech; usually benefits from regular physical activity; incapable of self-maintenance.
Severe	Marked delay in motor development; little or no communication skill; may respond to training in elementary self-help, e.g., self-feeding.	Usually walks barring specific disability; has some understanding of speech and some response; can profit from systematic habit training.	Can conform to daily routines and repetitive activities; needs continuing direction and supervision in protective environment.
Moderate	Noticeable delays in motor development, especially in speech; responds to training in various self-help activities.	Can learn simple communication, elementary health and safety habits, and simple manual skills; does not progress in functional reading or arithmetic.	Can perform simple tasks under sheltered conditions; participates in simple recreation; travels alone in familiar places; usually incapable of self-maintenance.
Mild	Often not noticed as retarded by casual observer, but is slower to walk, feed self, and talk than most children.	Can acquire practical skills and useful reading and arithmetic to a 3rd to 6th grade level with special education. Can be guided toward social conformity.	Can usually achieve social and vocational skills adequate to self-maintenance; may need occasional guidance and support when under unusual social or economic stress.

Source: Mental Retardation: A National Plan for a National Problem (Chart Book), p. 15, August 1963. Published for the President's Panel on Mental Retardation by the U. S. Department of Health, Education, and Welfare.

DEFINITION OF TERMS USED IN THE REPORT

DAY CARE PROGRAMS. Programs of treatment, educational, training, personal care, or sheltered workshop services provided on less than a 24 hour a day basis.

DIAGNOSIS AND EVALUATION. Coordinated medical, psychological and social services, supplemented where appropriate by nursing, educational or vocational services, and carried out under the supervision of qualified diagnostic personnel.

EDUCABLE. See "Mild Retardation" below.

GENERIC SERVICES. Community services, such as health, education and welfare activities, available to everybody including the retarded.

MILD RETARDATION. I.Q. of 51–70. Development slow. Children capable of being educated ("educable") within limits. Adults, with training, can work in competitive employment. Able to live independent lives.

MODERATE RETARDATION. I.Q. of 36–50. Backward in their development, but able to learn to care for themselves. Children capable of being trained ("trainable"). Adults need to work and live in sheltered environment.

PRESCHOOL NURSERY. A program of medical, psychiatric and psychological evaluation; nursery school training for the retarded child from age 3 through 6; and counseling for his parents. The Department of Mental Health is required by law to establish such nurseries in any city or town where six or more retarded children seek admission to such a nursery school.

PROFOUND RETARDATION. I.Q. of less than 20. Need constant care or supervision for survival. Gross impairment in physical coordination and sensory development. Often physically handicapped.

RETARDATION AREAS. Geographical territories comprised of cities and towns in which persons needing services for the retarded presently come and are expected to come to facilities for the retarded. These territories are so drawn as to assure availability of services within less than one hour's drive; are based on existing transportation routes; existing patterns of delivery of service; existing patterns of collaborative arrangements among private and public agencies; and the population base (see maps).

RETARDATION REGIONS. Geographical territories composed of several retardation areas in which the given population is served by a State residential school for the retarded, based generally on the school's accessibility by the region's population (see maps).

Severe Retardation. I.Q. of 20–35. Motor development, speech, language are retarded. Not completely dependent. Often, but not always, physically handicapped.

Sheltered Workshop. Services in a facility which provides comprehensive programs of paid work along with work evaluation, work adjustment training, occupational training, and transitional or extended employment.

Specialized Retardation Services. Services which meet one or more of the following criteria:

- 50% or more of the annual caseload is retarded.
- The services are provided to the retarded by public policy determination.
- A generic facility that is meeting the needs of a substantial number of retarded by an active agency policy for their inclusion.

State Residential Facility. A building or a complex of buildings housing a program of treatment, education, training, personal care, or sheltered workshop services on a 24 hour a day basis.

Trainable. See "Moderate Retardation" above.

BACKGROUND AND PROCEDURE

Fortunately, the national direction for a comprehensive attack upon retardation occurred simultaneously with a major statewide effort to expand and rationalize services for Massachusetts' retarded.

Advocates of expanded and rational statewide programs for the retarded view the objectives of the current state administration as a reflection of more than a decade of concentrated effort. Each administration has attempted to bring the needs of this long neglected segment of the population to the attention of the public, the legislature and the governmental and voluntary agencies charged with the responsibility for developing social, health and education programs.

The Massachusetts Mental Retardation Planning Project, which began its activities in July, 1964, was selected as the Commonwealth's instrument for developing a comprehensive program for those who are now or who may later be handicapped by retardation.

During the first two years, the Project concentrated its efforts upon:

- Developing a coordinated policy approach to programs for the retarded within Massachusetts.
- Providing an opportunity for all concerned citizens, experts and officials to contribute their knowledge and opinions.
- Studying in depth specific problems which required basic data before intelligent and informed recommendations could be made.

During the final 12 months, the Project staff will arrange for a series of conferences, workshops and consultation to inform and educate relevant agencies and groups and to provide information and support for state and local implementation.

FEDERAL BACKGROUND

In October, 1961, the late President John F. Kennedy appointed a panel of 27 scientists and specialists in the field of mental retardation and presented them with a mandate to prepare "A National Plan to Combat Mental Retardation." One year later, in October, 1962, "A Proposed Program for National Action to Combat Mental Retardation" was presented to the President.

This report outlined the size and scope of the problem in the United States and provided a blueprint for a comprehensive program for action to prevent mental retardation and to minimize its effects on human development. The President's Report formed the basis for the "Maternal and Child Health and Mental Retardation Planning Amendments of 1963" which authorized a total of $2.2 million to be made available to the states for planning to combat mental retardation. Of the 55 eligible jurisdictions, 54 participated in the program. This activity will result in a blueprint for action in each of the states and territories.

Recent federal legislation (Social Security Amendments of 1965) authorized funds "for assisting such states in initiating the implementation and carrying out of planning and other steps to combat mental retardation." This provision, which extends the initial activity for two additional years, will facilitate translating plans into action and permit continuation of interagency planning in greater depth, particularly at the community level.

INITIAL PROJECT DECISIONS

The Department of Mental Health and its Commissioner, Dr. Harry C. Solomon, was designated by former Governor Endicott Peabody and present Governor John A. Volpe as the state agency responsible for carrying out the purposes of the mental retardation planning grants.

Dr. Harry C. Solomon contracted with The Medical Foundation, Inc., Boston, Massachusetts, a voluntary health organization, to organize and operate the Massachusetts Retardation Planning Project.

A number of provisions assured an interdepartmental responsibility for carrying out the Project objectives. One provision related to the composition of the Project's policy making board. Another action concerned liaison staff. Project staff was supplemented by top officials appointed by the Commissioners of Education, Public Health, Mental Health, Public Welfare, and Rehabilitation. In addition, close communications were maintained with executive and legislative branches and relevant agency staffs, and through periodic meetings and conferences.

Governor Peabody appointed a Planning Board including the heads of all state agencies primarily or tangentially involved in the provision of services to the retarded. Dr. Alfred L. Frechette, Commissioner of Public Health, was appointed Chairman of the Planning Board.

In addition, Governor Volpe appointed the nine chairmen of Project task forces and an additional at-large member to the Planning Board. Members of the Board included leading citizens active in university, voluntary, and governmental agencies. A number of the Board members had been active in the struggle to develop necessary services for the retarded. Commissioners of state agencies, members of the Legislative Commission and subsequent appointees of the present government constituted the Planning Board of the Massachusetts Mental Retardation Planning Project. The Planning Board was the official policy making body of the Project. As such, it was empowered to "approve, disapprove or modify" the final draft of the Project plan.

During the first nine months of 1966, the Planning Board acted upon the reports of all nine task forces as well as the findings of Project staff for inclusion in the Project report.

TASK FORCES

Much time was devoted in the initial planning stages to careful selection of task force participants, developing guidelines for task force action and thorough orientation of chairmen and staff. Task forces were composed of a combination of key administrators responsible for programs serving the retarded, experts in the many professional areas and research fields concerned with problems in the retardation area and advocates and spokesmen for the retarded and their families. Nine task forces, with more than 135 individuals participating, studied the facts, heard expert testimony, deliberated, and prepared reports.

Subject areas of the nine task forces included:

- Residential Programs
- Educational Programs
- Manpower
- Community Services
- Prevention
- Public and Professional Awareness
- Administration and Finance
- Law and Legislation
- Evaluative and Administrative Research

THE PLANNING-IMPLEMENTATION CONTINUUM

From its very outset the Project attempted to increase the probability of a favorable reception of its recommendations.

Underlying the Project's operation was the premise that implementation began with initial planning decisions.

As a result of deliberations among participants in the planning effort, some significant action has already taken place:

- Project staff presented a sub-plan for the regionalization of state residential school services through its preparation of the state plan for facilities construction under P.L. 88–164. This plan has been accepted and put into effect by the Department of Mental Health. As an outgrowth of this activity, the Project staff participated in the drafting of the omnibus state legislation for a comprehensive mental health and retardation program in the Commonwealth.
- Members of the Task Force on Education are working closely with the Assistant Commissioner for Special Education, State Department of Education, a member of that task force, in revamping assessment criteria for entering special classes.
- The Task Force on Residential Programs is working closely with the Assistant Commissioner of Mental Health for Mental Retardation on changing basic patterns of residential treatment and training programs.
- The Project has received the agreement of the Massachusetts Rehabilitation Commission, Department of Education, Department of Mental Health, and Commonwealth Service Corps to participate in the development of program strategies based upon the outcome of a Project study of the post school adjustment of mental retardates in Massachusetts (supported by the U. S. Office of Economic Opportunity).
- Other examples of efforts aimed at implementation occurring during the first two years of the Planning Project included regional public hearings throughout the state, a one day program of informational workshop hearings at the annual convention of the Massachusetts Association for Retarded Children, a conference on the legal implications of the institutionalized retardate, and a joint meeting of the Legislative Commission on Mental Retardation with the Project Planning Board.

Each of these efforts illustrates a change in a substantive area of retardation programming or an attempt to stimulate and add to the receptivity of decision makers in generating or accepting recommended changes.

PROJECT SURVEYS

A comprehensive statewide inventory of facilities, programs, and services which deal exclusively with, or include, retarded persons in their operations has been completed.

The findings will present a clearer picture of the patterns of service and a profile of consumer patterns in the state. By utilizing these findings, local goals can be made operational with a more accurate assessment of the direction for future program development, existing facilities can be strengthened, and obvious gaps in service can be filled.

Priority determinations for new construction under P.L. 88–164 were based on findings of this inventory. The survey provided basic information on the availability of the spectrum of retardation services throughout the state.

The process of inventory taking encouraged general hospitals, clinics, and general community agencies to begin to identify more specifically the retarded persons they are serving. This undertaking precipitated new lines of communication within these service structures. Administrators noted that record keeping procedures needed overhauling in the light of new demands and approaches in health, education and welfare planning at the local, state, and national levels.

INVENTORY OF STATE AGENCIES

During July of 1965, the Project initiated an inventory of programs of state agencies designed to discover the scope and nature of the services presently being offered to the retarded by the departments and agencies of the Commonwealth. The objectives of the inventory included a description of the current and planned services of state departments and a determination of service gaps. This information provided data for pointing out areas for change, expansion, and consolidation. The study of the state departments was conducted with concern for revealing and surveying not only those services identified and expressly provided for the retarded but also those services which are provided as a part of the general services to the public.

Information accumulated as a result of the departmental studies provided important background data for the implementation task forces as they confronted administration, legal, legislative, and evaluation issues of programming and coordination. The results of the inventory will also be utilized by staff for advising and consulting with executive and legislative branches during the final phase of the Project.

POST SCHOOL ADJUSTMENT STUDY

Vocational training facilities, sheltered workshops, habilitation and employment opportunities for retarded young adults and adults were cited in the early stages of the Project as a major area for planning, strengthening existing services and introducing new services. At the present time, existing vocationally oriented agencies have spotty, and in some cases, inconsistent policies with respect to retarded applicants. A number of local associations for retarded children possess short term grants and others have no outside funding for workshops serving retardates with a wide range of competencies. Many groups have begun voicing discontent and frustration about poor coverage, unclear program objectives, nonstandardized procedures and in some cases unrealistic expectations for workshop training programs.

The Project concluded early in its first year that a study in depth of the characteristics of potentially employable and semi-employable retardates was necessary before program recommendations could be developed based upon obtainable information. A question underlying many facets of this issue is the relation, if any, between the socioeconomic status of the retardate and his family and his ability to find and take advantage of training and employment opportunities. To obtain this information, the project received a grant from the Research and Demonstration Section of the Office of Economic Opportunity which is now providing support for this important study.

During its last phase, Project staff will consider methods for restructuring training workshop and employment programs for the retarded based upon study findings. Project staff and subsequently the Office of Retardation (proposed by the Project) will assist the Massachusetts Rehabilitation Commission, the Department of Education and the Department of Mental Health in initiating demonstrations based upon study findings. The above departments have already committed themselves to participate in a technical advisory committee for the study and have promised to pursue implications derived from study findings which have a bearing on their responsibilities for the training, education and life adjustments of the mentally retarded.

PUBLIC INFORMATION ACTIVITIES

A key community relations and public information activity was the public hearing. During 1964 and 1965, public hearings were held under the combined auspices of the Mental Retardation and the Mental Health Planning Projects. Public hearings were held in Barnstable-Dukes, Berkshire, Worcester, Essex, Springfield and Boston areas.

The purposes of these hearings have been two-fold; to feed data into the decision making machinery of the projects and to increase local identification with, and commitment to, comprehensive planning. Important local information was gathered by people living and working in the community who are close to and familiar with the unique problems of their area. The planning process for the hearings involved staff work with local resources for developing community support, publicity, arranging for witnesses and numerous other activities incidental to such an endeavor. Special credit should be given to the many local groups, including Associations for Retarded Children who handled local details.

More than 200 witnesses testified. Those giving testimony ranged from top elected municipal officers and parents of retarded children to educators, practicing professionals and members of community voluntary associations. The panel hearing the testimony included members of the Planning Board, officers of the Massachusetts Association for Retarded Children and officials of the Departments of Mental Health and Education.

As would be expected, the testimony varied greatly both in the scope of subject and the quality of presentation, but the keen community interest and awareness of its needs were consistently apparent.

The success of the public hearings for giving valuable information on local needs and in mobilizing public awareness of mental retardation convinces the Project that support received from public hearings will be important for enhancing the implementation of key Project recommendations.

In addition to the public hearings, task forces held informal hearings in which they received testimony from officials, practitioners and parents and other community representatives drawn from all sections of the state according to the particular substantive areas under study.

A highpoint of the Project's public information "input" procedures was the major role taken by the Planning Project at the annual convention of the Massachusetts Association for Retarded Children in 1965. Three representatives of each task force met with representatives of local associations for retarded children, noting and discussing problems at a series of workshop hearings. Key members of the legislature participated in these sessions and ample press coverage was provided. A feature of the program was Governor Volpe's participation, his appraisal of the deliberations, and his personal endorsement of the Project's objectives.

RELEVANT FACTS AND GENERAL CHARACTERISTICS

A New Approach to Regionalization

RECOMMENDATIONS

AREAS

1. Comprehensive retardation programs should be provided in each of the 37 planned mental health and retardation areas in the state.

REGIONS

2. Initially, a minimum of four regions should be established by the Department of Mental Health to permit the decentralized administration of retardation programs.

MAJOR CONSIDERATIONS FOR DEVELOPING AREAS AND REGIONS

Sufficient Population Base for Guaranteeing Essential Services.

- Service areas should include from 75,000 to 200,000 inhabitants to comply with federal standards.
- To establish eligibility for federal assistance in the construction of community facilities, the Mental Health and Retardation Planning Projects divided Massachusetts initially into 4 regions and 37 areas. To maintain its eligibility for federal assistance, the Department of Mental Health must reevaluate, and when appropriate, redraw area and regional boundaries on an annual basis.

Full Utilization of Existing Public and Voluntary Facilities and Programs.

- Each of the 37 areas was drawn to include a general hospital. Care was taken to assure that no conflicts existed with the Hill-Burton General Hospital Construction Program.
- Most general hospitals will be eligible for federal funds for the construction of facilities offering short term or emergency care of the retarded.
- Local programs for the retarded are provided by a wide range of public and voluntary agencies. To facilitate the full participation of existing resources, a prescribed population base will serve to direct efforts toward the maximum operation necessary to efficiently utilize the available services in comprehensive programs at the local and regional levels.
- Area boundaries and regional divisions were drawn after study of current voluntary and public service boundaries. Department of Commerce regional plans, locations of community mental health centers, mental hospital, and residential facilities for the retarded were also determinants in the establishment of area boundaries.
- Massachusetts has a large investment in the state residential system for the retarded, both in terms of capital investment over the years and in concentrations of personnel. Present day residential schools will become the regional centers of the future, providing a variety of services in the areas and regions in which they are located.

Comparable Programs in Each Area and Region.

- Overlapping, duplication, fragmentation, and total absence of services can be avoided by planning on an annual basis by area boards, regional administrators, and state authorities. Areas with high need and low resources will be assured priority consideration in the development and strengthening of new or existing services.
- Equal guarantee of services to all persons can be achieved by a policy which supports comparable essential programs for the retarded in each area. This can be made feasible by proper use of local agencies and local coordination.
- Area jurisdictions over programs assure:
  - Equal accessibility to all retarded persons.
  - Continuity of service.
  - Accountability to all citizens.
  - A basis for rational fiscal planning.

A Central Public Authority with Area and Regional Jurisdictions.

- Division of the state into areas and regions conforms with the Act Establishing a Comprehensive Program of Mental Health and Mental Retardation Services (Chap. 735, 1966) which provides central, regional and area jurisdictions for mental health and retardation services by the Department of Mental Health. The act provides for coordinated planning, annual program review and fiscal control for jurisdictions at each level of the reorganized Department.

RESOURCE PROFILES BY AREA

Areas outlined on each of the following five maps are described alphabetically within each of the four regions. Cities and towns within each area are listed along with the existing specialized facilities serving the retarded. The Department of Mental Health's plans for retardation and mental health facilities are also detailed for each area. A narrative description of each area complements the resource profile.

Resource and need ranks referred to in the text are taken from information described in detail in the section on "Priorities Among Areas" which follows this section and from relevant appendix tables.

Area profiles are included as a guide to state and local leadership for the development of comprehensive retardation programs.

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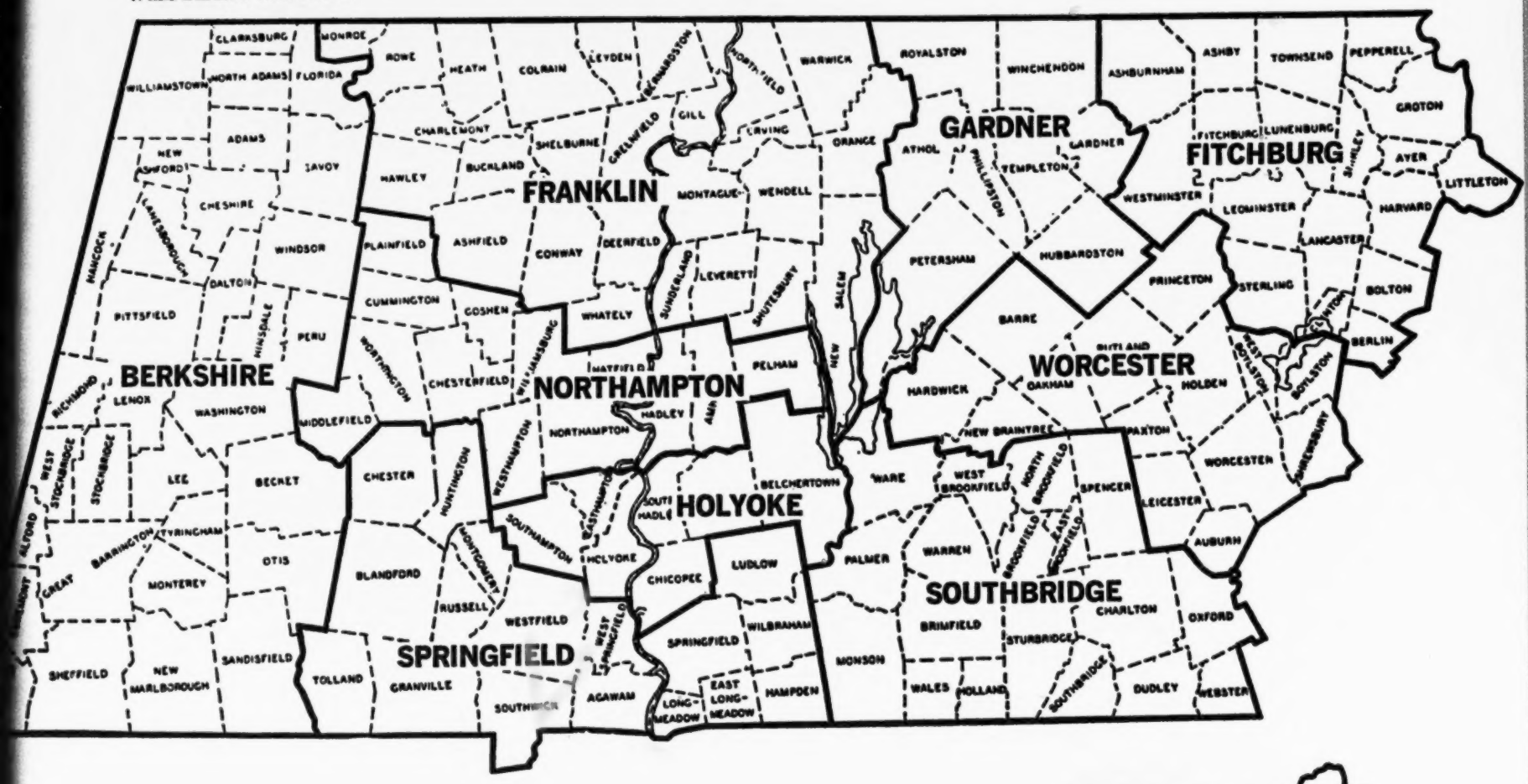
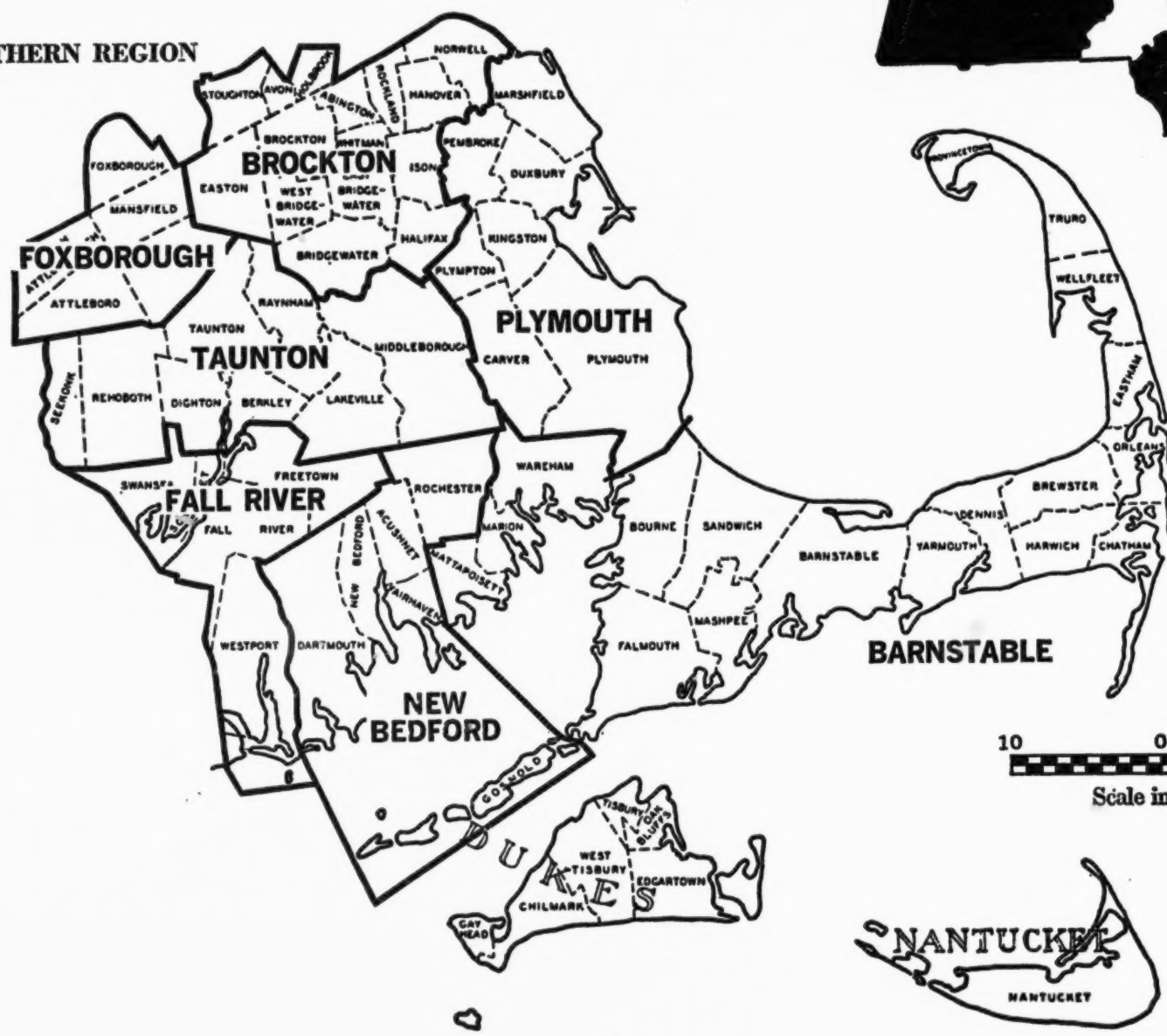
RETARDATION REGIONS AND AREAS

WESTERN REGION



SOUTHERN REGION



RETARDATION REGIONS AND AREAS

NORTHERN REGION

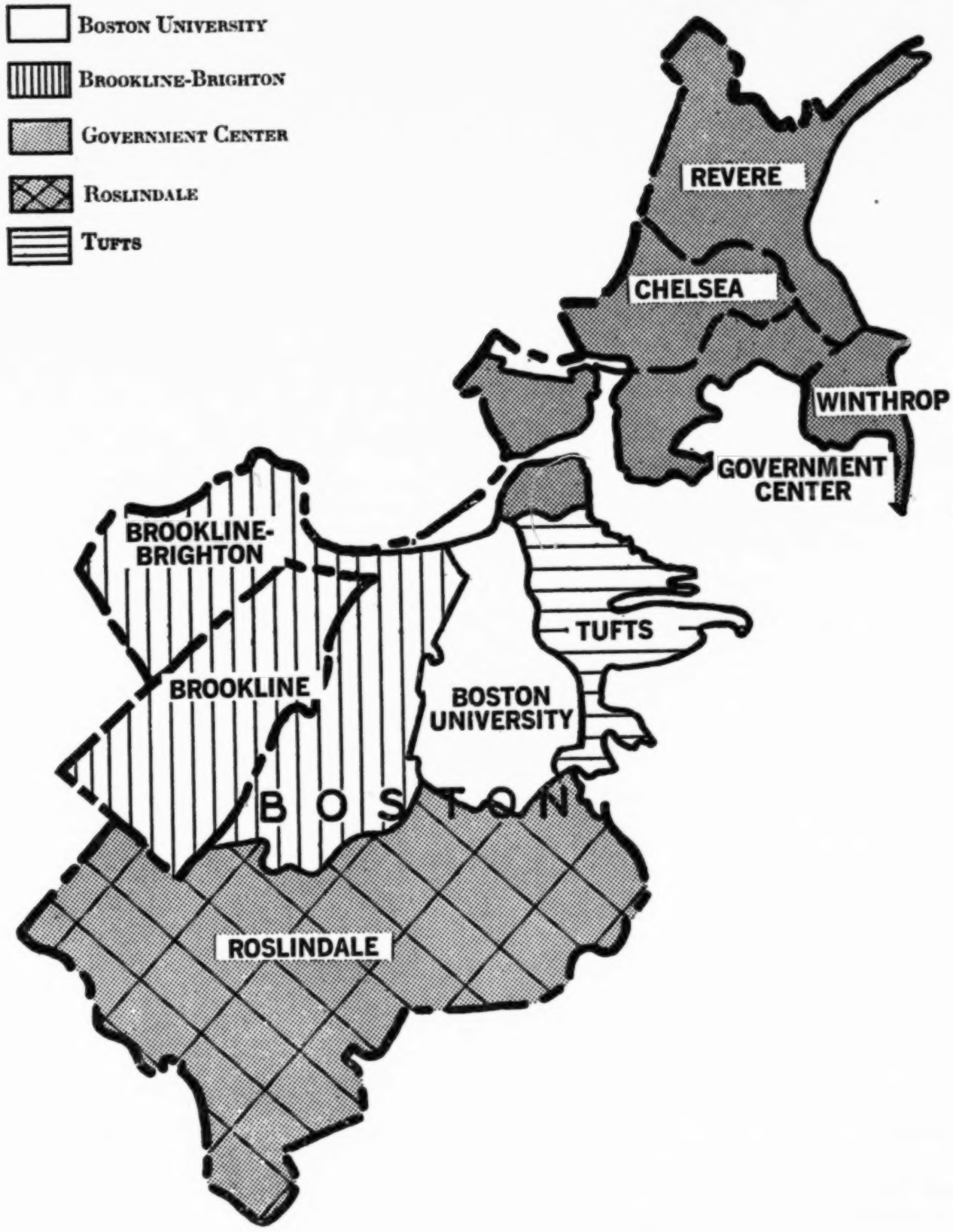
CENTRAL REGION

For Area Detail of Greater Boston See Insert Map

10 0 10

Scale in Miles

GREATER BOSTON RETARDATION AREAS



CENTRAL REGION

1960 Population — 1,624,034

Major Residential Retardation Facility — Wrentham State School

BOSTON UNIVERSITY

Community Retardation area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
South End (less tracts G1, G2, G3, G4), Back Bay (tracts J3, J4, K3, K5), Roxbury (less tracts S2, S4, S5, S6, V2), Dorchester North (less tract T1)	• Boston City Hospital Guidance Center • Boston University Psycho-Educational Clinic • Preschool Nursery of the Psycho-Educational Clinic

This area encompasses the north central part of Boston including parts of Back Bay and Roxbury, the South End, and the western portion of North Dorchester. It has a population of 158,065, and is one of the highest socioeconomic need areas in the state. This area has the highest percentage of families with an annual income of less than $3,000, the highest percentage of recipients of Aid to Families with Dependent Children (AFDC), and the largest percentage of deteriorating and dilapidated housing.

Needs related to retardation show that this area ranks first in number of people on state school waiting lists and ranks fourth on state school admissions. This area ranks second among the state planning areas in number of pupils enrolled in special classes in the public schools.

This area has two diagnostic and evaluative facilities for the retarded. Both are attached to Boston University; one of these two also operates in cooperation with Boston City Hospital. The Psycho-Educational Clinic of Boston University operates a preschool nursery which includes a large percentage of retarded children.

A comprehensive center is programmed for this area at University Hospital to include diagnosis and evaluation, a large day program, and 10 emergency beds for the retarded. This center will be staffed by a comprehensive team within the next four years if plans are completed and appropriations made.

Generic complementary programs which include the retarded are primarily recreational in nature. Agencies report large numbers of retarded persons being served in this capacity.

BROOKLINE-BRIGHTON

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Brighton, Brookline, Jamaica Plain, Back Bay (tracts K4A, K4B, J5, S1), Roxbury (tracts S2, S4, S5, S6, V2)	• Brookline Mental Health Clinic • Brookline Preschool Clinic for Retarded Children • Children's Hospital Medical Center • Massachusetts Mental Health Center • Pollock School, Inc.

This area, in the western section of greater Boston, includes all of Brookline, Brighton, Jamaica Plain and parts of Back Bay and Roxbury, with a population of 205,992. The area has a very mixed socioeconomic profile indicated by its very high percentage of recipients of AFDC, and its low rate of persons with less than five years of education. Housing in these communities is reasonably intact in comparison to other sections of the state.

In regard to retardation indicators, this area ranks generally low in admissions to state schools, preschool program waiting lists, and special class enrollment in the public schools. However, the area is in the middle range in terms of state school waiting lists.

This area is rich in diagnostic and evaluation facilities, including the Children's Hospital Medical Center, Massachusetts Mental Health Center, Brookline Mental Health Clinic and the Brookline Preschool Clinic for Retarded Children. A private school in this area has both a day and a residential program.

The Children's Hospital Medical Center is both a local and regional specialized facility, serving large numbers of retarded children. It has plans completed for a new building to serve the retarded, in addition to its present program.

The generic complementary services in the community report generally excellent participation by retardates. Settlement houses, other recreational services, some of the numerous general hospitals in the area, Judge Baker Guidance Center, the Brookline Court Clinic, the district office of the Massachusetts Society for The Prevention of Cruelty to Children and six licensed group homes show substantial services on behalf of and interest in retarded among their general caseload.

There are no other short term plans for expansion of facilities pending.

GOVERNMENT CENTER

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Charlestown, Chelsea, East Boston, North End, Revere, West End, Winthrop	• Goodwill Industries • Massachusetts Eye and Ear Infirmary • Massachusetts General Hospital • Morgan Memorial Nursery • New England Rehabilitation-for-Work Center • North Suffolk Mental Health Center • Preschool Nursery for Retarded Children

This area of 185,108 people includes part of Boston, as well as some of the towns to the north of the city. While the resources of the area are fairly extensive, the area is still one of high need as shown by the socioeconomic indicators. Urban renewal has apparently disorganized the traditional stable community setting of the West End and replaced the former residents with high cost, high rise housing. The relocated have tended to move to surrounding communities which also are subject to urban renewal developments.

Special retardation need indicators show that this area ranks last in the state for state school admissions. Special class enrollment in the public schools for the retarded is relatively high as is the rank for state school waiting lists.

Specialized facilities consist of two major diagnostic and evaluative facilities: the Massachusetts General Hospital and the Massachusetts Eye and Ear Infirmary. A guidance center in East Boston and a specialized rehabilitation-for-work center also carry on diagnostic and evaluative services. Two preschool nurseries are located in the area, one operated by Morgan Memorial Goodwill Industries and one by the greater Boston Association for Retarded Children. Morgan Memorial Goodwill Industries also operates a sheltered workshop for this area.

Many generic services exist in this area and serve considerable numbers of retardates. The generic agencies sampled in the study, reported serving a total of 260 retardates last year.

With the construction of the new government center, plans are programmed for a comprehensive center with a full range of services for the retarded. This center will have eight emergency beds for the retarded and will be linked to the existing facilities at Massachusetts General Hospital.

GRAFTON

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Bellingham, Blackstone, Douglas, Grafton, Hopedale, Mendon, Milford, Millbury, Millville, Northbridge, Sutton, Upton, Uxbridge	• Grafton State Hospital • The Ledges • Opportunity Workshop

Thirteen small towns, with a total population of 83,438, comprise this rural area. Two hundred forty-eight square miles are populated with 336 people per square mile. The socioeconomic indicators show this area to be slightly higher than the mean for the state. This area ranks lower than average for preschool program waiting lists and special class enrollment in the public schools.

The only diagnostic and evaluative facility in the area is at Grafton State Hospital, which provides services to the mentally ill. The local association for retarded children sponsors a preschool nursery and a sheltered workshop. A small private residential school is located in Hopedale. Fifty percent of the residents of the facility come from outside of the area.

The generic facilities in the sample are sparse and the few responses indicated no participation of retardates in the general services.

No specialized facilities, programs or services for the retarded are planned in the immediate future for this area.

MEDFIELD

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Canton, Dedham, Franklin, Medfield, Medway, Needham, Norfolk, Norwood, Plainville, Sharon, Walpole, Westwood, Wrentham	• Attleboro Area Association for Retarded Children Nursery • Charles River Preschool Nursery • Charles River Workshop • Medfield State Hospital • Milford-Franklin Area Preschool for Retarded Children • Norfolk Guidance Center • Norwood Preschool Nursery • Preschool Nursery for Retarded Children • Wrentham State School

This area, comprised of 13 relatively large towns, has a total area population of 157,508 distributed over 209 square miles with an average density of 755 persons per square mile. Many of these towns house upper middle class residents who commute to Boston to work. The area has few people with an income of less than $3,000, and few AFDC recipients. It is interesting to note, however, that this area ranks average in percentage of persons who have not completed five years of education, and has an average amount of dilapidated housing.

Retardation need indicators show generally less than average need as compared with the rest of the state.

The Medfield area has several outstanding facilities. Wrentham State School, with a population of 2,247, has a diagnostic and evaluation facility, a day program, and a large residential program for the retarded. Medfield State Hospital has a very active research and rehabilitation program and has demonstrated research interest in the retardates among the hospitalized mentally ill.

The Norfolk Guidance Center located in Norwood provides diagnostic and evaluative services and supervises two preschool nursery programs for the retarded in Norwood and Needham.

One preschool nursery serves Medway, and another nursery sponsored by the Charles River Association for Retarded Children operates in Needham. The local association also sponsors a sheltered workshop for school age and young adults in Needham. The Attleboro Association for Retarded Children sponsors a preschool nursery in Plainville.

There is a plan for five additional new buildings at Wrentham State School. There is also a plan for additional staff at the Norfolk Guidance Center, including another nursery school teacher and a mental health coordinator.

This area has quite a number of generic services. However, few indicated that they serve the retardates.

NEWTON

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Newton, Wellesley, Weston	• Newton Mental Health Center • Wellesley Human Relations Service

This area, with a population of 126,716, covering 45 square miles and having an average density of 2,832 persons per square mile, consists primarily of high socioeconomic communities. It ranks last in the state in terms of the need indicators of the "characteristics" table in all but one category.

The area is high on the waiting list for preschool programs yet low in numbers enrolled in special classes. The area is average in terms of the two state school indicators.

Specialized facilities in Newton consist of a diagnostic and evaluative center. The public school system of Newton provides an excellent guidance department which exceeds all other areas in quantity and quality of personnel. Retarded children are accommodated in the public school system from ages 5 through 20, with special educational programs designed for the high school aged retardate.

Programs in the public school system, the family services, and the recreational components of this area tend to rank this area as better than average in the use by retardates of generic services.

The Wellesley Human Relations Service provides diagnostic and evaluative service and consultation to schools in Wellesley. In addition, it provides a preschool checkup service, short term treatment, and human relations seminars to first year nurses at Newton-Wellesley Hospital. The program is limited to those persons who live and work in Wellesley.

There is a preschool nursery planned for Newton. In addition, discussion has taken place concerning the possibility of a sheltered workshop for Newton school age and postschool age retarded persons.

ROSLINDALE

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Hyde Park, Roslindale, West Roxbury, Dorchester, South Dorchester, Central (tracts T4A, T4B, T5A, T5B, T7B, T8A, T8B, T9, T10, X1)	• Boston State Hospital • Dorchester Guidance Center • Dorchester Preschool Nursery Clinic • Roslindale Preschool Nursery

This area includes the southeastern section of the city of Boston, consisting of West Roxbury, Roslindale, Hyde Park, Central and South Dorchester with a population of 230,187. It is an area composed of both high and low income families as evidenced by its low percentage of families with earnings of less than $3,000 but ranking fourth in the state for percentage of AFDC recipients.

The data from the specialized retardation factors indicate that this area is first in the state in the number of admissions to state schools and is second in the number of people on the waiting list at state schools, thus indicating a high degree of need for these facilities.

Specialized facilities for the retarded in the Roslindale area include two diagnostic and evaluation facilities: one in a hospital and one in a child guidance center. The state hospital services are many and varied, including a home treatment program and present use of state hospital buildings for certain retardation programs.

Complementary generic resources in the area are relatively few. A Youth Service Board Reception Center for delinquent youths operates in this area and serves the eastern portion of Massachusetts. This facility indicates that a substantial number of their population show signs of retardation.

A 500 bed comprehensive center has been programmed for this area in the immediate plans of the Department of Mental Health.

SOUTH SHORE

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Braintree, Cohasset, Hingham, Hull, Milton, Quincy, Randolph, Scituate, Weymouth	• Cerebral Palsy Nursery School • Cerebral Palsy Treatment Center • Diagnostic Nursery • Occupational Training Center • Preschool Nursery Clinic • (2) Preschool Nursery Clinic for Retarded Children • South Shore Mental Health Center • South Shore Preschool Nursery • Therapeutic Nursery

This area includes nine communities south of Boston, three of which are on the coast; the geographical location of these communities gives this area its designation as the South Shore.

This area has a moderately high socioeconomic status ranking according to income, housing and welfare factors used in the needs profile. The population is 251,417 for 122 square miles or an average of 2,060 people per square mile.

The South Shore ranks low in state school residents and state school waiting lists. It has less than average special class enrollments in public schools but ranks high in waiting lists for preschool programs.

This area is rich in specialized facilities. The South Shore Mental Health Center, which has supervisory relations with six preschool nurseries and one occupational training center, served almost 200 people with retardation last year. The United Cerebral Palsy of the South Shore Area, Inc. provides diagnostic and evaluative services and also operates a preschool nursery. The above two programs served 194 retarded persons with cerebral palsy during a recent 12 month period.

To complete the spectrum of a full range of services in the South Shore, an emergency 10 bed unit and two additional nurseries are programmed for the near future.

A considerable number of the generic services that were sampled showed participation by retardates from the area. The general hospital in Quincy, as well as the court clinic and recreational services, reported substantial involvement in programming for the retarded.

TUFTS

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
South End (tracts G1, G2, G3, G4) South Boston, Dorchester North (tract T1)	• Community Workshops, Inc. • Hayden Goodwill Inn and School • Jewish Vocational Service, Inc. • Tufts New England Medical Center • Vocational Adjustment Center • Hayden Goodwill Industries

The Tufts New England Medical Center, the major medical complex in the area, is the origin of the name for this Boston area of 57,557 people. The Tufts area is high in socioeconomic need indicators, exceeded only by the Boston University area in terms of the percentage of AFDC recipient and low income rates.

The area ranks first in need for the state with regard to the specialized retardation indicators.

Tufts provides the only diagnostic and evaluative services to the area. Three sheltered workshops, one sponsored by the Greater Boston Association for Retarded Children, one sponsored by Jewish Vocational Service, and one by the Community Workshop, Inc., are located in this depressed section of Boston. The Hayden Goodwill Industries of Morgan Memorial, Inc. provides a residential program for adults, 31 of whom are retarded.

The generic agencies sampled in this area report a considerable number of retardates using their programs. Recreational agencies, Massachusetts Society for the Prevention of Cruelty to Children, and Family Service are the major sources of complementary services.

No additional facilities have been planned for the immediate future in this area.

WESTBOROUGH

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Ashland, Dover, Framingham, Holliston, Hopkinton, Hudson, Marlborough, Millis, Natick, Northborough, Sherborn, Southborough, Sudbury, Wayland, Westborough	• The Anbar Home of Millis Academy, Inc. • Framingham Preschool Nursery Clinic • Greater Framingham Mental Health Clinic • Greater Framingham Preschool Nursery • Marlborough Nursery School • Massachusetts Correctional Institution, Framingham • Westborough State Hospital

This area is comprised of 15 communities. Framingham, the principal population center, is located midway between Boston and Worcester, the two largest cities of the state. Transportation is easily available in order to use the facilities of both metropolitan areas. The population is 164,974 for 266 square miles, with an average density of 631 persons per square mile.

The socioeconomic level of the communities in this area is high. However, there are some depressed pockets within the area.

Retardation need indicators show relatively low need with the exception of state school admissions, which rank close to the median for the state.

The specialized facility for the retarded in this area is the Greater Framingham Mental Health Clinic. The Massachusetts Correctional Institution for Women in Framingham provides services for female defective delinquents. In addition, this facility reports services to 84 females who are retarded.

There are three nursery schools in this area, all receiving supervision from the Greater Framingham Mental Health Clinic.

Westborough State Hospital serves mentally ill retardates and those retardates suffering from tuberculosis.

The Greater Framingham Mental Health Clinic has a programmed addition of two nursery teachers, a mental health coordinator and a nurse.

Generic facilities sampled ranked average for the state in the numbers of retarded reported utilizing general community services. The Massachusetts Society for the Prevention of Cruelty to Children reported a sizeable number of retardates served, as did the Framingham Court Clinic. The Lyman School for Boys, a Youth Service Board facility, serves 42 retarded boys in their general population.

NORTHERN REGION

1960 Population — 1,527,445

Major Residential Retardation Facility — Walter E. Fernald State School

BEAVERBROOK

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Belmont, Waltham, Watertown	• Beaverbrook Guidance Center • Farrell Hall Preschool Nursery for Retarded Children • Gaebler Children's Unit • Metropolitan State Hospital • Walter E. Fernald State School • Warren School Preschool Nursery for Retarded Children

Beaverbrook, located northwest of Boston, contains Belmont, Waltham and Watertown. There is considerable variety among the three cities in terms of socioeconomic level and need. The 21 square mile area has a population of 123,220 and an average density per square mile of 5,484 persons.

Special retardation indicators also show a varied profile; this area ranks high in admissions to state schools, and in waiting lists at state schools, though it has a median rank for special class enrollment.

Four diagnostic and evaluative programs are located in and serve this area: Walter E. Fernald State School, Metropolitan State Hospital, Gaebler Children's Unit of Metropolitan State, and Beaverbrook Guidance Center. Walter E. Fernald State School serves the northern region of the state; Metropolitan State Hospital serves large numbers of suburban communities principally northwest of Boston; Gaebler Children's Unit of Metropolitan State serves mentally ill children throughout the Commonwealth. In contrast, the Beaverbrook Guidance Center is principally concerned with the needs of local children. Walter E. Fernald State School has a full range of retardation services and an active research program. Its total population, including the Templeton Colony mentioned in the Gardner area, is 2,622. There are two preschool nurseries, one in Waltham and one in Belmont.

Nine new buildings are programmed for Walter E. Fernald State School and Templeton Colony in the near future.

The local court clinic is active as a diagnostic facility for those appearing before the court, and the local association for retarded children is active in providing, with the city of Waltham, day activity programs for the retarded of school and postschool age.

CAMBRIDGE

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Cambridge, Somerville	• Cambridge Mental Health Center • Cambridge Nursery Clinic • Children's Developmental Clinic • Somerville Guidance Center

The Cambridge area is situated north of Boston and includes the cities of Cambridge and Somerville. Total population is 202,413 over 10.2 square miles, with 19,883 people per square mile. This area is somewhat mixed in its socioeconomic profile, having a relatively high rate of AFDC recipients, and average rates in income less than $3,000, and in deteriorating and dilapidated housing.

The area also demonstrates a mixed picture of specialized need factors by ranking relatively low on state school admissions and special class enrollments in the public schools, while ranking high on waiting lists for both state schools and preschool programs.

The Cambridge area has three diagnostic and evaluative facilities and one preschool nursery. The Children's Developmental Clinic in Cambridge served 118 retarded children during a recent 12-month period, drawing part of its population from several communities outside of Cambridge. Its highly specialized program has attracted wide usage and acclaim.

A preschool nursery program is planned for the immediate future in the city of Somerville.

Additional staff is also planned for the diagnostic and evaluative facility in Somerville and the guidance center in Cambridge.

The generic facilities and programs serving the retarded show average participation by the retarded. Recreational agencies show the highest level of inclusion.

All resources fall far short of the level of need expressed in this area.

CONCORD

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Acton, Boxboro, Carlisle, Concord, Lincoln, Maynard, Stow	• Concord Nursery School for Retarded Children • Minute-Man Association for Retarded Children Workshop • Walden Clinic

This area consists of seven towns with a total population of 37,868, encompassing 108 square miles, with an average density of 351 people per square mile. These communities hold the third highest socioeconomic rank in the state according to our indicators.

There is no waiting list in the Concord area for preschool programs for the retarded, but this area ranks relatively high on waiting lists for state schools. It has the lowest special class enrollment.

One small diagnostic and evaluative clinic provides limited services. However, the local Association for Retarded Children sponsors a preschool nursery and a sheltered workshop program for school age and adult retardates.

The Massachusetts Society for the Prevention of Cruelty to Children, a family service agency, and the local public welfare department, are active in this area.

A coordinated program of mental health and retardation services with emphasis on training is currently being implemented in this area.

DANVERS

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Beverly, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester, Marblehead, Middleton, Peabody, Rockport, Salem, Topsfield, Wenham	• Danvers Preschool Nursery • Danvers State Hospital • Gloucester Preschool Nursery • Heritage Training Center • North Shore Mental Health Center • Hathorne State School

This area north of Boston, bordering the ocean and including Cape Anne, is composed of 14 communities with a total population of 208,442. It has an area of 195 square miles and an average density of 1,069 persons per square mile. The socioeconomic status is relatively high, falling just below the top third of all areas of the state. Specific need indicators show a less than average need compared with the rest of the state in state school waiting lists, state school admissions, preschool waiting lists, and special class enrollment in the public schools.

The Danvers State Hospital and the North Shore Mental Health Center currently comprise the two diagnostic and evaluative facilities. There are two preschool nursery programs, sponsored by the North Shore Association for Retarded Children, and a sheltered workshop in Salem.

This year a new state school will open at Danvers, ultimately providing a 500 bed facility with a full range of services for the whole northeast section of Massachusetts.

The complementary generic services show average use by retardates. The Massachusetts Society for the Prevention of Cruelty to Children (North Shore District Branch) report shows a significant number of retarded persons in their caseload.

HAVERHILL

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Amesbury, Boxford, Georgetown, Groveland, Haverhill, Merrimac, Newbury, Newburyport, Rowley, Salisbury, West Newbury	• (2) Northern Essex County Association for Retarded Children Preschool Nursery • Northeastern Essex Mental Health Clinic • Te Lo Ca

The Haverhill area on the extreme northeastern section of the state, bordering on the ocean and New Hampshire, is composed of 11 communities; it is 181 square miles, with a population of 93,760 and an average density of 518 persons per square mile. The socioeconomic status of this area is average for the state; however, some of the communities have a very low economic position. The rank for deteriorated and dilapidated housing is the fourth highest in the state.

This area ranks fourth in the state for numbers on state school waiting lists, but near the mean for the state on all other specialized need indicators.

The existing specialized facilities for the retarded include one diagnostic and evaluative clinic, and two preschool nurseries, one of which is in Haverhill and the other is in Newburyport. Both of these nurseries are sponsored by the Northern Essex County Association for Retarded Children. A private residential facility in Groveland, with a capacity of 40, serves severely retarded children. Ninety-five percent of the residents of this facility come from areas outside the Haverhill area.

Complementary generic facilities show minimal participation by retardates in these programs. However, the family service agency in Haverhill shows a number of retardates receiving family counseling and supportive services.

No specialized facilities and programs are planned for the immediate future. However, the Department of Mental Health is planning an addition of three staff members to the existing diagnostic and evaluative clinic. These include a nursery school teacher, a mental health coordinator, and a nurse.

LAWRENCE

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Andover, Lawrence, Methuen, North Andover	• (2) Greater Lawrence Guidance Center Preschool Clinics • Greater Lawrence Association for Retarded Children Sheltered Workshop • Greater Lawrence Guidance Center, Inc. • Preschool Nursery for Retarded Children

The Lawrence area consists primarily of the city of Lawrence and the three surrounding small towns of Andover, Methuen, and North Andover. Lawrence is an old mill town with severe social and economic need. It has a large percentage of people with incomes less than $3,000, and ranks high in percentage of people with less than 5 years of education. There is also a considerable amount of deterioration in the housing. The population totals 125,833 covering 87 square miles, with an average density of 1,448 persons per square mile.

The specialized retardation indicators show that this area ranks high in state school admissions and waiting lists. It ranks near the median for the state in preschool program waiting lists and enrollment in special classes in the public schools.

The Lawrence area has one diagnostic and evaluative facility, the Greater Lawrence Guidance Center. There are three preschool nurseries for the retarded and a sheltered workshop in Lawrence. This area is equivalent to the Boston University area, ranking first in terms of over-all resources available.

Generic programs indicate high participation by retardates in the community. These agencies include recreational, family service agencies, and the district office of the Massachusetts Society for the Prevention of Cruelty to Children.

A comprehensive team is programmed as an addition to the existing clinic.

LOWELL

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Billerica, Chelmsford, Dracut, Dunstable, Lowell, Tewksbury, Tyngsborough, Westford, Wilmington	• Greater Lowell Mental Health Center • The Merrimack Valley Goodwill Industries • Preschool Nursery Clinic • New Comprehensive Mental Health Center in Lowell

The Lowell area consists of the city of Lowell and eight surrounding smaller towns. Lowell, an old industrial city, has suffered in recent years from serious unemployment. The socioeconomic indicators in the study showed that this area, in spite of its history of a shifting economic base, now ranks better than average on all indicators, except deteriorating and dilapidated housing. Only two areas in Boston show poorer housing, statistically.

This area covers 184 square miles with an average density of 964 people per square mile.

Specialized retardation indicators place the Lowell area at an average rank of about 23.

The Lowell area has a total population of 177,547 with one diagnostic and evaluative facility, one preschool nursery, and a sheltered workshop operated by the Merrimack Valley Goodwill Industries.

There are existing plans for the opening of a comprehensive center with a full range of services for the retarded in Lowell, including emergency residential care. This will be the first comprehensive center of its kind in the state. This center will include mental health services as well as retardation services.

The Lowell area includes the public health hospital of Tewksbury, serving indigent chronically ill persons. Among the total population in this hospital of 1,200 persons, 125 are retarded.

The other generic services in the community show average participation by retardates. Local recreational programs indicated no involvement with retarded persons.

LYNN

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Lynn, Lynnfield, Nahant, Saugus, Swampscott	• Child Guidance Center of Greater Lynn • (2) Lynn Preschool Nursery

The Lynn area on the north shore line of Massachusetts is composed of five communities; the city of Lynn is the population center.

The Lynn area is composed of 140,796 people in an area of 35.4 square miles with an average density of 3,979 persons per square mile.

The socioeconomic status of this area has a mixed profile. There are a large percentage of recipients of AFDC while a relatively small percentage of people have an education of less than 5 years.

Lynn also presents a mixed profile in the special retardation need indicators. This area ranks higher than average for special class enrollment and state school waiting lists. The rank for preschool nursery waiting lists is relatively low.

There is one specialized diagnostic and evaluative facility in Lynn and two preschool nursery programs, both in the city of Lynn. One is sponsored entirely by the North Shore Association for Retarded Children.

The generic services of this area show reasonably high participation by retardates in the community. The recreational services rank high, as do the family service agencies.

There is an existing plan for a comprehensive team to augment the staffing pattern at the Greater Lynn Mental Health Center. This team will provide significant specialized services to the retarded in this area.

MALDEN

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Everett, Malden, Medford	• Malden Mental Health Center • Malden Preschool Nursery • Medford Preschool Nursery

This area of 166,191 persons is comprised of three industrial cities north of Boston. In 16.6 square miles, the area's population has an average density of 9,975 per square mile. However, the residents of Malden, Medford, and Everett obtain many of their services from Boston proper.

Socioeconomically, this area receives an average ranking. However, the area ranks very high in specialized indicators: state school admissions (5), state school waiting lists (6) and preschool program waiting lists (6). The area has a relatively low rank in special class enrollment in the public schools.

A new diagnostic and evaluative facility has recently opened in Malden and one preschool nursery exists under the auspices of the Greater Boston Association for Retarded Children. An additional preschool nursery under the same auspices exists in Medford.

The Malden Hospital shows a considerable interest in retardation through its diagnostic and evaluative services. The local recreational programs also include the retarded in its activities. The local court clinic reports services to 10 school age and adult retarded persons out of 150 who appeared before the district court in a recent 12 month period.

No immediate additions to specialized facilities are planned. However, the Department of Mental Health is planning for an additional preschool nursery teacher in the Malden Mental Health Center program.

MYSTIC VALLEY

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Arlington, Bedford, Burlington, Lexington, Winchester, Woburn	• Arlington Preschool Nursery • The Lila Sanatorium • Mystic Valley Children's Clinic • Winchester Preschool Nursery

This area has a population of 152,055 and includes six suburban communities, with a total area of 66 square miles and an average density of 2,304 people per square mile. The socioeconomic profile shows a generally very high status as compared with the rest of the state.

The area tends to rank very low in special class enrollment, but much higher in state school admissions and waiting lists.

This area has one diagnostic and evaluative facility in Lexington, the Mystic Valley Children's Clinic. There are two preschool nurseries, one in Arlington and one in Winchester. An additional preschool nursery is planned for Arlington.

A small residential program for severely retarded in Woburn has a capacity of 11 children. Eighty percent of the residents of the facility come from places outside this area.

Since these communities are part of metropolitan Boston, many families use the specialized services in Boston. However, the demand for specialized services locally has put great pressure on existing local resources.

Generic services sampled in the area show that recreational agencies report some retardates using their programs.

Two additional nursery teachers are programmed for this area on a short range planning basis.

READING

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Melrose, North Reading, Reading, Stoneham, Wakefield	• Eastern Middlesex Guidance Center • North Reading Rehabilitation Center • Occupational Center of Eastern Middlesex Association • Preschool Nursery for the Retarded

The Reading area is comprised of five communities with a total population of 99,324, distributed over 41.2 square miles with an average density of 2,408 people per square mile. These towns include Reading, North Reading, Melrose, Stoneham, and Wakefield. Socioeconomically, this area ranks as one of the highest in the state — second only to Newton.

Its retardation need indicators show that it is an area with relatively low need. This area ranks in the bottom third for state school admissions, special class enrollment in public schools and preschool program waiting list.

The Reading area has major resources: the North Reading Rehabilitation Center, with an accommodation of 200 persons on a day and residential basis, is presently serving 107 retardates; the Eastern Middlesex Guidance Center and preschool nursery are located in the city of Reading; the Eastern Middlesex Association for Retarded Children operates an occupational training center in Reading; the North Reading Rehabilitation Center presently draws its population from many cities and towns, as far south as Boston for its day program, and all of eastern Massachusetts for its residential program.

Generic services sampled show better than average inclusion of retardates in their ongoing programs, especially in the recreational field.

An additional building, a gymnasium-auditorium, at the North Reading Rehabilitation Center is planned in the near future.

SOUTHERN REGION

1960 Population — 733,833

Major Residential Facility — Paul A. Dever State School

BARNSTABLE

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Barnstable, Bourne, Brewster, Chatham, Dennis, Eastham, Falmouth, Harwich, Marion, Martha's Vineyard, Mashpee, Mattapoisett, Nantucket, Orleans, Provincetown, Sandwich, Truro, Wellfleet, Wareham, Yarmouth	• Barnstable Child Guidance Center • Cape Cod Association for the Advancement of Retarded Children Preschool Nursery Clinic • Martha's Vineyard Guidance Center • Parents School for Atypical Children, Inc.

This area includes the three counties, Barnstable, Dukes, Nantucket. It is generally known as Cape Cod and the Islands. The area is affected by the advantages and disadvantages of a large resort population. Population grows tenfold during the summer period. The resident population of 95,067 lives in many small rural isolated communities spread over 512 square miles with an average density of 174 people per square mile. Socioeconomic data indicates that this area is the fourth highest in the state for percentage of persons earning less than $3,000. However, it ranks low with respect to persons with less than 5 years of education. Although this area has high poverty based on income, it has relatively small amount of deteriorating and dilapidated housing.

Based on specialized retardation need indicators, the Barnstable area averages twelfth in the state in terms of state school admissions, state school waiting lists, preschool waiting lists and special class enrollment.

This area has very limited resources for the retarded. It has two diagnostic and evaluative facilities, one located in Pocasset and one on Martha's Vineyard. The facilities tend to serve children primarily. No facilities are available for retarded adults. Only one preschool nursery for the retarded exists. One residential care facility, whose population largely comes from outside of the Cape Cod area, is located in Chatham.

Barnstable area ranks very low in the availability of generic services, but those that do exist indicate an interest in including the retarded in their programs.

No short range plans for expansion of facilities for the retarded are presently in evidence. However, the Department of Mental Health projects the addition of a preschool nursery teacher, one mental health coordinator and one public health nursing advisor within the immediate future.

BROCKTON

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Abington, Avon, Bridgewater, Brockton, East Bridgewater, Easton, Halifax, Hanover, Hanson, Holbrook, Norwell, Rockland, Stoughton, West Bridgewater, Whitman	• (3) Brockton Preschool Nursery • Judge Harry K. Stone Clinic • Massachusetts Correctional Institution, Bridgewater • Prevocational Training Center • St. Coletta School for Exceptional Children

This southeastern area is composed of 15 municipalities, with Brockton the largest city in the area. The total population of the area is 185,140. The socioeconomic status is relatively high based on all four socioeconomic factors studied. The area has above average need in terms of the specialized need indicators for the retarded. The 233 square miles of the area has an average density of 796 persons per square mile.

There are two diagnostic and evaluative facilities in the Massachusetts Correctional Institution at Bridgewater. The Brockton Association for Retarded Children sponsors two preschool nurseries and one prevocational training center. This area is close to two major state school facilities, which provide comprehensive services on a day and residential basis. St. Coletta-by-the-Sea is a residential facility for exceptional children accommodating 242 retarded children, drawing its residential population from many communities in the state. The day program of the facility serves the local area, as well as part of the Plymouth area.

Generic agencies in the Brockton area show an average participation of retardates. The Institute for Juvenile Guidance, a facility of the Youth Service Board, the Brockton District of the Massachusetts Society for the Prevention of Cruelty to Children, and the Boy Scout Council serve a considerable number of retardates in their programs.

Brockton is presently being considered as a testing ground for a collaborative health, education, rehabilitation and welfare program. Results of these efforts will probably culminate in a variety of new health and welfare programs, as a demonstration of collaborative public-private, state-local services. This may alter Brockton's priority rank.

FALL RIVER

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Fall River, Freetown, Somerset, Swansea, Westport	• Crystal Springs Nursery • Fall River Area Mental Health Clinic • (2) Greater Fall River Preschool Nursery • Greater Fall River Association for Retarded Children Sheltered Workshop • United Cerebral Palsy of Greater Fall River • New Comprehensive Mental Health Center in Fall River

This industrial area is composed of five cities and towns. The total population of 131,734 suffers from high unemployment and large pockets of poverty. The 150 square mile area has an average density of 880 people per square mile. The area rates highest in the state in deteriorating and dilapidated housing. It also ranks near the top for the state in low income and lack of education.

The area presents a low rate of admission to state residential schools. The preschool program waiting list and special class enrollment rank near the highest in the state. This data seems to indicate that this low socioeconomic area keeps their retarded in the community and needs new resources close to the people.

New specialized facilities have been programmed and appropriations have been made for Fall River. These facilities will provide a full range of services to complement the services of the county mental health clinic in the area. The new facility will have five emergency beds for retarded persons.

The local association for retarded children has worked with the city of Fall River to provide programs of recreational activity. The association also sponsors two preschool nurseries and a sheltered workshop.

A small private residential program for the most seriously retarded children, comprising 24 in number, is available in the town of Assonet. The generic complementary services in the area show average inclusion of retardates in their programs.

FOXBOROUGH

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Attleboro, Foxborough, Mansfield, North Attleboro, Norton	• Attleboro Area Association for Retarded Children Nursery • Attleboro Area Mental Health Center • Foxborough State Hospital

This area consists of five communities, one of which is industrial. The total population is 66,622 with an area of 114 square miles and an average density of 582 persons per square mile.

From the specialized retardation factors, this area ranks high on state residential school admissions and waiting lists. The area is close to both Wrentham State School and the Paul A. Dever State School. This area shows no waiting list for preschool programs and ranks higher than average in the state for special class enrollment in the public schools.

The Attleboro Mental Health Clinic and the Foxborough State Hospital are the two diagnostic and evaluative facilities in the immediate area. The area association for retarded children operates a preschool nursery in Attleboro assisted by the Department of Mental Health.

The complementary generic services sampled show few retardates participating. However, retarded persons do participate in community vocational programs.

No specialized facilities, programs and services are planned for this area for the immediate future.

NEW BEDFORD

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Acushnet, Dartmouth, Fairhaven, Gosnold, New Bedford, Rochester	• New Bedford Mental Health Clinic • (2) New Bedford Preschool Nursery for Retarded Children • Opportunity Center of Greater New Bedford, Inc.

This coastal area in southeastern Massachusetts is comprised of six communities with the city of New Bedford being the population center. The area includes the Gosnold Islands across Buzzards Bay. The total population of the area is 138,803 with 144 square miles and an average density of 965 persons per square mile. New Bedford is still an active center for commercial fishing, but its shifting industrial base has produced high unemployment and high socioeconomic need. The socioeconomic indicators show this area to rank first in the state with numbers of persons with under five years of education and third in the state with people earning less than $3,000. It also ranks high among the 37 areas of the state in persons receiving welfare benefits.

This very low socioeconomic area ranks third in the state in the utilization of special classes in the public schools. It ranks almost as high for preschool waiting lists. Statistics also demonstrate a significantly high number of working married women. The ranks in regard to the use of state schools show that there is relatively little utilization of this type of facility as a solution to the needs of this area's retarded citizens.

There is one diagnostic and evaluative facility in New Bedford operated by the Bristol County Mental Health Clinics, Inc., and there are two preschool nurseries, and a sheltered workshop for those of school and postschool age.

This area ranks average for the state in the utilization of generic services by retardates. Retarded persons are reported to participate in recreational programs in the area. These programs also serve the general population.

PLYMOUTH

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Carver, Duxbury, Kingston, Marshfield, Pembroke, Plymouth, Plympton	None

The Plymouth area includes seven towns with a total population of 37,911. It is an area of 244 square miles and an average population density of 156 per square mile. This historic coastal area shows considerable rural isolation and depends economically on resort and tourist trade. The socioeconomic profile indicates higher than average need for the state.

The area shows, through the retardation need indicators, a tremendous need for all kinds of retardation services. The area ranks low in state school admissions, yet it shows extremely high ranks in the three other special retardation indicators.

There are no specialized facilities for the retarded in this area of any kind. Efforts to help mobilize communities in this area are now underway with leadership being given by a newly organized association for retarded children. The generic services that were sampled by the study show that the Massachusetts Society for the Prevention of Cruelty to Children serves a large number of retardates in this area through the district office of this statewide children's protective service.

TAUNTON

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Berkley, Dighton, Lakeville, Middleboro, Raynham, Rehoboth, Seekonk, Taunton	• Taunton Mental Health Clinic • Paul A. Dever State School • Preschool Nursery Clinic • Taunton State Hospital

This area near the Rhode Island border consists of eight towns with Taunton being the largest population center. The total population is 78,286 in an area of 270 square miles. There is an average density of 290 persons per square mile. The socioeconomic indicators show this area to be less than average among areas for the state. It ranks high for persons earning less than $3,000 and for people having less than five years of education. This area is relatively high in special class enrollment in the public schools, yet all other need indicators are low in rank for this area, with no children reported on preschool waiting lists.

There are three diagnostic and evaluative facilities in this area. The largest specialized facility is the Paul A. Dever State School, which has a total population of 2,200 on a day and residential basis. The Taunton State Hospital, nearby, provides significant diagnostic and evaluative services to the retarded who are mentally ill. Taunton State Hospital presently serves 109 retardates. The Taunton Mental Health Clinic, a branch of the Bristol County Mental Health Clinics, Inc., served 84 retardates in a recent 12 month period. There is a preschool nursery program in Middleboro sponsored by the Brockton Association for Retarded Children. The Taunton public school system sponsors a preschool nursery in the school system.

A sampling of generic programs in this area reveals that Lakeville Hospital, a public health facility, has an ongoing relationship with Paul A. Dever State School and Wrentham State School, providing orthopedic services to both institutions. The children's unit at Lakeville serves many retarded children. Recreational agencies in this area provided services to over 100 retardates in their general programs within a 12 month period.

WESTERN REGION

1960 Population — 1,254,874

Major Residential Facility — Belchertown State School

BERKSHIRE

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Adams, Alford, Beckett, Cheshire, Clarksburg, Dalton, Egremont, Florida, Great Barrington, Hancock, Hinsdale, Lanesborough, Lee, Lenox, Monterey, Mt. Washington, New Ashford, New Marlborough, North Adams, Otis, Peru, Pittsfield, Richmond, Sandisfield, Savoy, Sheffield, Stockbridge, Tyringham, Washington, West Stockbridge, Williamstown, Windsor	• Berkshire County Association for Retarded Children Training Center • Berkshire Mental Health Center • Goodwill Industries of Pittsfield, Inc. • Northern Berkshire Child Guidance Center • Pittsfield Preschool Nursery • Riverbrook School • Vesper Hill Nursery School

This area is comprised of all the communities in Berkshire County. The area has a population of 142,183 covering over 926 square miles with an average density of 153 persons per square mile. It is the most mountainous area in the state, containing many small towns and hamlets scattered throughout the Berkshire ranges. Rural isolation and low population density tend to prevent easy accessibility and utilization of resources.

Socioeconomic data show that Berkshire has a median rank, compared with other areas in the state, of persons with less than 5 years of education, but ranks higher in the other socioeconomic indices. The area does not have a great amount of deteriorating and dilapidated housing.

Specialized retardation need indicators show that few persons in Berkshire County are on waiting lists for state residential schools and preschool nurseries. Few are admitted to state schools, and there are only a small number of special classes for the retarded in the public school system. More specifically the area has the lowest number of people on the state school's waiting list compared with all other areas of the state.

Existing special agencies consist of two diagnostic and evaluative facilities located in Pittsfield and North Adams. Two preschool nurseries and one sheltered workshop are located in Pittsfield. There are two private residential facilities, both serving a combined population of 25, in the southwest section of the area.

Existing generic resources sampled, which serve the retarded, report minimal participation by retarded persons. However, recreational programs did report occasional participation of a few retardates.

Programmed facilities on a short range basis include a 100 bed diagnostic and evaluative, day and residential facility to be staffed by a comprehensive team. This facility will be located in Pittsfield. A new preschool nursery is programmed in the near future for North Adams. There is exceptional community interest on behalf of the retarded in this area, particularly in Pittsfield and North Adams. Plans are underway to provide a full range of specialized services to the retarded in this area.

FITCHBURG

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Ashburnham, Ashby, Ayer, Berlin, Bolton, Clinton, Fitchburg, Groton, Harvard, Lancaster, Leominster, Littleton, Lunenburg, Pepperell, Shirley, Sterling, Townsend, Westminster	• Fitchburg Preschool Nursery • North Central Mental Health Center • North Worcester County Association for Retarded Children Sheltered Workshop • Perkins School • Westminster Preschool Nursery

This area is comprised of 16 moderately small communities and the urban areas of Fitchburg and Leominster. The total population is 148,623 covering an area of 433 square miles with an average population per square mile of 291. The socioeconomic status is near the mean for the areas of the state with the exception of a very high ranking for deteriorating and dilapidated housing. There is considerable rural isolation in a large geographical spread of rolling wooded countryside. The area shows low need in all specialized retardation factors with the exception of special class enrollment in public schools. Public school enrollment in special classes is near the mean as compared with all areas of the state.

There is a diagnostic and evaluation facility in the city of Fitchburg located on the grounds of the Burbank Hospital. This facility shows an active participation in both testing and the supervision of two preschool nursery programs. The local sheltered workshop is sponsored by the North Worcester Association for Retarded Children.

A moderately large residential private school for the retarded of school age and adults is available in the town of Lancaster. This facility serves retardates from many cities and towns in Massachusetts, with a few persons from the immediate area.

Complementary generic agencies serve a generally high number of retardates in the community. Recreational facilities served 156 retardates, reported in a 12 month period. The Industrial School for Boys at Shirley, a Youth Service Board Facility, serves 21 retarded out of a population of 691. However, this facility serves persons from many communities in Massachusetts.

At the State Teachers College in Fitchburg, one of the training centers for specialized teachers in the state, a new educational, diagnostic and treatment center is programmed for the near future. This will provide a full range of service including a 75 bed residential unit and an expanded training program for special class teachers. At present the Fitchburg area is the farthest area geographically from any existing state school. The maintenance of adequate parent-child relationships when children are placed in state schools is made difficult by this factor.

FRANKLIN

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Ashfield, Bernardston, Buckland, Charlemont, Colrain, Conway, Deerfield, Erving, Gill, Greenfield, Hawley, Heath, Leverett, Leyden, Monroe, Montague, New Salem, Northfield, Orange, Rowe, Shelburne, Shutesbury, Sunderland, Warwick, Wendell, Whately	• Franklin County Association for Retarded Children Sheltered Workshop • Franklin County Mental Health Center • Preschool Nursery for Retarded Children

The 26 small towns of Franklin County are located in the mountainous northern area of Massachusetts. It borders Vermont on the north, and the Connecticut River splits the territory from north to south. Greenfield and Montague have the largest population density with the other towns and hamlets more sparsely inhabited. This expansive geographic area encompasses only 54,864 people over an area of 701 square miles for the lowest average population density in the state of 78 persons per square mile.

The socioeconomic profile of the Franklin area shows a large number of people with income of less than $3,000, but shows relatively few people with less than 5 years of education.

State school admissions and special class enrollment rank very high in this area as compared with other areas in the state. Waiting lists for both state schools and preschool nursery programs show a weak demand for these programs. This seemingly indicates that state schools and the special classes in the public schools have absorbed a considerable number of the retardates requiring service in the area.

A diagnostic and evaluative facility exists in Greenfield. A comprehensive team is planned for this area to augment operating services. There is one preschool nursery in Greenfield sponsored by the local association for retarded children and the Department of Mental Health, and a sheltered workshop in Greenfield sponsored by the Franklin County Association for Retarded Children.

Franklin area has better than average participation of retardates in generic programs sampled for the state. The Massachusetts Society for the Prevention of Cruelty to Children is very active in this area, as is the local association for retarded children. The Franklin County Public Health Hospital is also active in providing several programs to retarded children including a dental service and physiotherapy.

GARDNER

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Athol, Gardner, Hubbardston, Petersham, Phillipston, Royalston, Templeton, Winchendon	• Gardner State Hospital • Templeton Colony Annex (Walter E. Fernald State School)

The Gardner area is composed of eight towns. The total population is 45,885 with Athol and Gardner the largest centers. The towns are located in a territory of 289 square miles with an average population density of 158 per square mile. This central northern group of communities is located in rolling, heavily wooded countryside. The socioeconomic profile indicates relatively high need as compared with other areas in the state.

The specialized retardation factors used in the study show that the Gardner area ranks extremely high in all these indicators of need except for number of persons on state school waiting lists.

With the exception of Gardner State Hospital for the mentally ill and the Templeton Colony Annex of Walter E. Fernald State School located in Templeton, there are no specialized facilities for the retarded. There are few generic services available. Those that do exist tend to have district offices either in Fitchburg or Worcester, a good distance away from the towns in the area.

HOLYOKE

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Belchertown, Chicopee, Easthampton, Granby, Holyoke, South Hadley, Southampton	• Belchertown State School • Dall Memorial Preschool Nursery • Holyoke-Chicopee-Northampton Mental Health Center • Holyoke Preschool Nursery

This area is comprised of seven cities and towns. The area includes Chicopee which is part of greater Springfield. Holyoke is the population center of the area. The population of the 184 square mile area is 153,123 with an average population density of 825 persons per square mile.

Socioeconomic indicators show this area to be better than average as compared with other areas in the state. The specialized retardation indicators show this area to be relatively low in its rank for state school admissions and waiting lists, as well as special class enrollment; yet the area ranks high for preschool waiting lists.

The specialized facilities for retardates include two existing diagnostic and evaluative programs: one at Belchertown State School in Belchertown, and the other at Holyoke-Chicopee-Northampton Mental Health Center located in Holyoke. There are two preschool nurseries: one in Chicopee and one in Holyoke. A large residential program exists at the state school accommodating 1,255 persons from all over the state.

There are extensive programs planned for this area. Seven new buildings are planned for the state school at Belchertown and a comprehensive team for the clinic in Holyoke. In addition, three new preschool nurseries are programmed.

The sample of generic programs in the area suggests that average participation of retardates occurs in these services, primarily through the service of the local district office of the Massachusetts Society for the Prevention of Cruelty to Children.

NORTHAMPTON

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Amherst, Chesterfield, Cummington, Goshen, Hadley, Hatfield, Middlefield, Northampton, Pelham, Plainfield, Westhampton, Williamsburg, Worthington	• Hampshire County Association for Retarded Children Nursery • Northampton State Hospital

The population of this area is 55,439 with an average population density of 169 persons per square mile. The area contains 328 square miles. It includes 12 small towns and the city of Northampton. Situated on the Connecticut River in the western part of the state, many of these small towns are isolated and deficient in resources.

Socioeconomic indicators show this area to have relatively high need compared with other areas of the state. It ranks particularly high as an area with persons with less than five years of education and people earning less than $3,000.

Special retardation indicators show that this area ranks extremely low in special class enrollment, in preschool program waiting lists and in state school waiting lists. It also ranks somewhat low in state school admissions as compared with other areas in the state.

There is no diagnostic and evaluative facility located in the immediate area. However, the Holyoke-Chicopee-Northampton Clinic in Holyoke does serve Northampton. The Northampton State Hospital serves mentally ill retardates and now accommodates 162 in this category. There is one preschool nursery in Northampton and one is now planned for Amherst.

Colleges and universities in this area could be likely sources for the education of specialized and ancillary personnel and for research and demonstration projects if the area were provided with a suitable retardation facility and staff.

Generic agencies sampled indicated an average capability for serving retardates. The principal community facilities serving the retarded and their families are the family service agency and recreational agencies.

SOUTHBRIDGE

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Brimfield, Brookfield, Charlton, Dudley, East Brookfield, Holland, Monson, North Brookfield, Oxford, Palmer, Southbridge, Spencer, Sturbridge, Wales, Ware, Warren, Webster, West Brookfield	• Central Youth Guidance Center • Monson State Hospital • Southbridge Preschool Nursery

This is a large geographical area in south, central Massachusetts on the Connecticut River consisting of 18 moderately small towns. The total population is 100,679 with an area of 464 square miles and an average population density per square mile of 217 persons. The area includes sections of rural isolation. Socioeconomic indicators show this area to be better than average in the state, except for a relatively high rate of people with less than five years of education.

One preschool program exists in this area. State school admissions are high (rank eighth in the state). However, this area ranks second lowest in the state on state school waiting lists and relatively low in the use of special classes in the public schools.

The area has two diagnostic and evaluative centers. One of them, Monson State Hospital for Epileptics, serves 1,591 epileptics who are also retarded. This is the only program of its kind in Massachusetts. It has an active day and residential program, a summer camping program, and a school program.

The Central Youth Guidance Center has been developed recently and offers diagnostic and evaluative services. The preschool nursery in Southbridge is supervised by Worcester Youth Guidance Center out of the city of Worcester.

Twelve new buildings are currently planned as additions to Monson State Hospital for Epileptics.

There are few generic services in the area, and most of the district offices of state health, education and rehabilitation departments are located in the major metropolitan area of Worcester, on the northern boundary of the area.

SPRINGFIELD

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Agawam, Blandford, Chester, East Longmeadow, Granville, Hampden, Huntington, Longmeadow, Ludlow, Montgomery, Russell, Southwick, Springfield, Tolland, Westfield, West Springfield, Wilbraham	• Child Guidance Clinic of Springfield • Magic Carpet Nursery • Springfield Goodwill Industries, Inc. • Springfield Nursery Clinic • Westfield Area Child Guidance Center

The Springfield area includes the city of Springfield, the third largest city in Massachusetts, and 16 additional small towns, some suburban and some rural. It has a less than average socioeconomic ranking compared to the areas in the rest of the state. The total population of the service area is 296,799 spread over 464 square miles. The average population density per square mile is 639 persons.

Retardation need indicators show the Springfield area is currently very high in special class enrollments, while having very low ranks for state school admission and state school waiting lists. A relatively high number of children await entrance into preschool nursery programs.

There are two diagnostic and evaluation facilities in the area: The Child Guidance Clinic of Springfield, and Westfield Area Child Guidance Center. There are two preschool nurseries and a sheltered workshop operated by the Springfield Goodwill Industries. A collaborative program for retardates sponsored by the Goodwill Industries and the Hampden County Association for Retarded Children offers a unique administrative arrangement for a sheltered workshop for retarded persons.

There is a long range plan for a new state school in Springfield to accommodate 500 persons and to provide a full range of services. In addition, a comprehensive community mental health center is currently being planned.

Generic services sampled showed that recreational programs, the family service agency, a Youth Service Board facility, and a licensed group home include the retarded of the communities in their programs. The Hampden Association for Retarded Children also runs a volunteer home visiting program to assist families with retarded family members.

WORCESTER

Community Retardation Area by Towns, Cities, and Census Tracts	Existing Retardation Facilities
Auburn, Barre, Boylston, Hardwick, Holden, Leicester, New Braintree, Oakham, Paxton, Princeton, Rutland, Shrewsbury, West Boylston, Worcester	• Day Care Facility • The Devereux Foundation • The Memorial Hospital • (2) Occupational Training Center • Preschool Nursery Clinic • Worcester Preschool Nursery • Worcester State Hospital • Worcester Youth Guidance Center

This midstate area is comprised of 13 towns and the city of Worcester. The total population is 257,307 with an area of 371 square miles and an average population density of 694 persons per square mile. This area constitutes the second largest area in the state and includes the second largest city.

The socioeconomic status of the area is lower than average for the state.

Worcester as an area ranks low in state school admissions and waiting list indicators. It ranks almost average in special class enrollments compared with the other areas of the state.

This area has three major diagnostic and evaluative facilities. These include the Worcester State Hospital complex, the Worcester Youth Guidance Center and Memorial Hospital. Three preschool nurseries are supervised by the Worcester Youth Guidance Center. In addition, there are three occupational training centers and workshops, all associated with Worcester State Hospital and the Guidance Center. The hospital, itself, offers a residential program to mentally ill retardates. One hundred eighty-five retarded persons were reported in residence at the State Hospital.

On a long range planning basis, there is a 500 bed comprehensive state school programmed for the Worcester area. There is also on a short range basis a 150 bed comprehensive service facility programmed for Rutland Heights, north of Worcester. Also programmed in the near future is a 25 bed addition to the comprehensive center complex now on the grounds of Worcester State Hospital.

The sample of generic services in Worcester shows a relatively large number of agencies serving retardates in the community. The principal agencies reporting service to retardates include the association for retarded children, recreational agencies, family service agencies and six licensed group homes.

CONSTRUCTING AN AREA PROFILE

A profile of the areas according to needs and resources for the retarded has been constructed by the Project. Each area was ranked in a need scale and a resource scale to establish its position of priority for program development and federal assistance for the construction of specialized retardation facilities on a short and long range basis.

To describe a composite retardation picture for each area, it was necessary to collect information which could effectively describe both resources and needs. Two distinct sets of questions were formulated to accomplish this end.

First:

- What resources in an area are currently serving the retarded and their families?
- To what extent are these resources offering a full range of services?
- How available are generic community services to the retarded?
- How comprehensive are the retardation programs within a given area?

Second:

- What evidence is available to show need for retardation services?
- How can we assess relevant socioeconomic factors associated with retardation?
- What "hard" data are available from a mandatory universal public program for identifying the retarded?
- Can public demand for retardation service be used as a sensitive indication of relative need?

"RESOURCE" DEFINED

The meaning of "resource" is based on several statistical indicators which have both local and statewide significance. Data have been drawn from service statistics collected through a statewide inventory of more than 279 agencies providing specialized and generic services to the retarded throughout 37 areas of the state.

Each agency was asked to indicate the degree to which it presently provides six federally recommended services essential to the retarded and their families: diagnosis and evaluation, treatment, education, training, custodial care, and sheltered workshops. The availability of these services and programs essential to the retarded were surveyed in each area. In addition, actual facilities housing these programs were surveyed. Agency programs in each area were then assessed for the inclusion, or lack of inclusion, of retarded persons in each facility, program, and service category offered.

On the basis of reported programs for the retarded, the following five resource indicators were used to achieve a picture of the extent of care provided to the retarded and their families in each area: diagnostic and evaluation programs, preschool age programs, school age programs, post-school age programs, and generic programs. Each resource indicator was assigned equal weight as a measurement of an area's total resource ranking.

The number of specialized and generic programs were quantified for each of the 37 areas on a five point scale, ranging from one (representing the least resources) to five (representing most resources). (In Appendix E, footnote symbols are used for programs lacking facilities within the geographical boundaries of an area, and for existing programs which lack service components.)

"NEED" DEFINED

The meaning of "need" is based on several statistical indicators which have both local and statewide significance for the development of community programs and facilities for the retarded. They have been drawn from United States census statistics as well as service statistics of the Massachusetts Departments of Mental Health, Education, and Public Welfare.

To determine a set of significant need indicators, a panel of 17 judges studied 18 socioeconomic and specialized retardation factors. Judges weighed the importance of each factor in contributing to an area's need for retardation programs and facilities. The panel consisted of the commissioners of state health, education, and welfare agencies responsible for serving the retarded, as well as chairmen of the task forces of the planning project.

Strongest weights were assigned to the following four socioeconomic indicators:

- Annual family income of less than $3,000.
- Persons with less than five years of education.
- Recipients of Aid to Families with Dependent Children.
- Percentage of total housing units considered deteriorating or dilapidated.

Specialized retardation need indicators receiving priority included the following:

- State residential school admissions.
- State residential school waiting lists.
- Preschool nursery program waiting lists.
- Public school special class enrollment.

A need profile composed of all eight indicators was developed for each of the 37 areas in the state. Each area's need profile was then ranked with all other areas in the state on a 1 to 37 scale. Each area was also ranked on a 1 to 37 point scale of composite need for all need indicators.

COMPOSITE NEED-RESOURCE RANKS

The 37 retardation areas of the Commonwealth are listed in the following chart according to their over-all need and their provision of resources for retarded persons. An area's relative need-resource rank is determined by its position on a five point scale ranging from highest to lowest need and on a five point scale ranging from limited to major resources.

SUMMARY CHART OF RELATIVE NEED-RESOURCE RANKS OF RETARDATION AREAS

OVERALL NEED	RESOURCES: *Limited*	*Average*		*Major*	
Highest	Gardner Plymouth	Roslindale Fall River	Tufts	New Bedford	Boston University Lawrence
	Barnstable Haverhill		Malden	Franklin Government Center Lynn	Cambridge
Average	Berkshire Southbridge	Lowell Taunton	Springfield		Brockton Worcester
	Grafton	Holyoke	Danvers Fitchburg Foxborough	Beaverbrook Brookline-Brighton	
Lowest		Northampton Westborough	Mystic Valley Newton	Medfield	Concord Reading South Shore

An area's priority can be determined by reading the summary chart from its top left-hand corner to its bottom right-hand corner. Gardner and Plymouth areas show the highest over-all need and the most limited resources relative to other areas. This gives these areas a first priority designation for program development and federal assistance for the construction of retardation facilities. On the basis of empirical and measurement considerations, an area's over-all need was determined to be more powerful than its resource rank as an indicator of its relative position. Therefore, the chart should be read across the page beginning at the highest need category.

Thus,

AREA PRIORITIES

1	2	3	4	5
6	7	8	9	10
11	12	13	14	15
16	17	18	19	20
21	22	23	24	25

CONSIDERATIONS IN ASSESSING "NEED"

A most difficult task for planners and administrators charged with the responsibility of developing programs for the retarded is to devise measures of the anticipated demand for needed services for this disabled group. Since a definitive prevalence survey has not yet been undertaken in Massachusetts, three alternative procedures were considered. Community studies in other sections of the United States and in Great Britain could be superimposed upon the Massachusetts population with the accompanying presumption that they would be representative of the Massachusetts population. Or, the national prevalence rates could likewise be assumed for Massachusetts. Neither of these approaches warranted acceptance of a formula from an outside source. The third approach, the one used for the profile of needs in this report, combines factors associated with retardation which can be computed from Massachusetts demographic and service statistics.

As more "hard" data become available and are refined as potentially, more reliable and valid indicators of retardation needs and resources, they will be incorporated in annual state plans developed by the Department of Mental Health for purposes of program development and retardation facilities construction.

ADDITIONAL CONSIDERATIONS

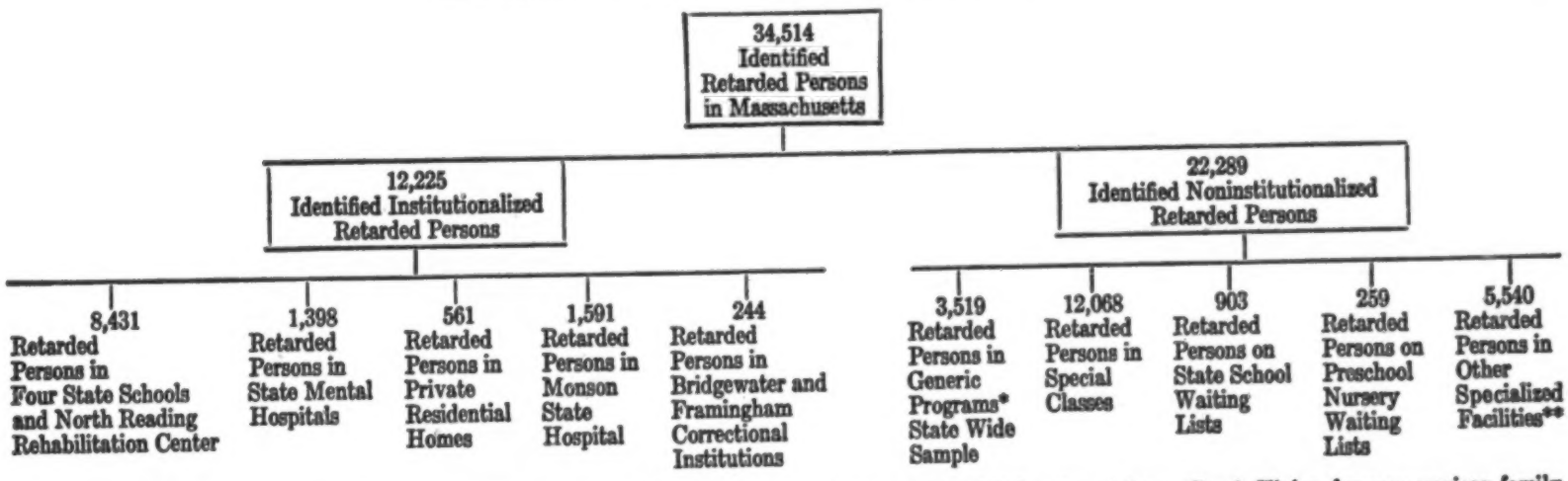
A serious attempt has been made in our rationale for developing area profiles to include significant factors for determining an area's rank. Yet, a strong case can be made for the consideration of the following additional factors which should also influence decisions about an area's need for programs and facilities:

- Resources in densely populated low socioeconomic urban areas may not reflect the ability of persons to secure needed services.
- People residing in high socioeconomic areas may, through greater mobility, take advantage of resources outside their areas through considerations of consumer choice rather than necessity.
- Rural areas may lack a sufficient population base for the development of some specialized types of services.
- Facilities which educate and train personnel should be given some consideration for their potential contributions for preparing critical manpower for programs throughout the state.

NUMBER OF RETARDED PERSONS SERVED BY STATE AND LOCAL FACILITIES

The President's Panel on Mental Retardation estimated that 3% of the population are afflicted by retardation. Applying this estimate to Massachusetts, there are 165,000 possible retarded persons living in the Commonwealth. A total of 34,514 or 20% of the possible 165,000 were identified by a statewide inventory conducted in the last quarter of 1965. The results of the inventory are indicated in the following chart.

IDENTIFIED RETARDED PERSONS IN THE POPULATION 1965



*115 generic agencies reported. Includes retarded persons in Boys Clubs, Boy Scouts, Cerebral Palsy Associations, Court Clinics, day care services, family services, general hospitals, Massachusetts Rehabilitation Commission, Massachusetts Society for the Prevention of Cruelty to Children, private child guidance clinics, settlement houses and community centers, and the Division of Youth Service.

**Includes Mental Health Centers, Preschool Nurseries, Sheltered Workshops, Children's Developmental Clinic, and Teaching Hospitals.

Source: Massachusetts Mental Retardation Planning Project, Inventory of Facilities, Services and Programs, 1965–1966.

AGE AND RETARDATION CHARACTERISTICS

The following tables indicate the age and retardation characteristics of the 17,765 persons (12,225 institutionalized, 5,540 non-institutionalized) served in specialized agencies.

TABLE 1

AGE GROUPINGS OF RETARDED PERSONS SERVED BY 164 SPECIALIZED AGENCIES

Age Level	*Number*	*Percent*
Preschool (ages 0–5)	1,835	11.9%
School Age (ages 6–18)	5,743	37.2
Adult (over 19 years of age)	7,863	50.9
Total Classified*	15,441	100 %

Source: Massachusetts Mental Retardation Planning Project, Inventory of Facilities, Services and Programs 1965–1966.
*2,324 undetermined.

TABLE 2

DEGREES OF RETARDATION OF PERSONS SERVED BY 164 SPECIALIZED AGENCIES

Degree of Retardation	*Number*	*Percent*
Mild	5,239	38.2%
Moderate	3,223	23.5
Severe	3,249	23.7
Profound	2,004	14.6
Total Classified*	13,715	100 %

Source: Massachusetts Mental Retardation Planning Project, Inventory of Facilities, Services and Programs, 1965–1966.
*4,050 undetermined.

EXPENDITURES BY STATE AGENCIES

In fiscal 1965, seven state agencies, serving 35,411 retarded persons, expended more than $43 million on behalf of the retarded. In addition, local communities spent more than $6 million on behalf of the retarded in public school special classes and public assistance programs. A detailed breakdown of the spending of each agency follows.

EXPENDITURES FOR THE RETARDED AND NUMBERS SERVED BY STATE AGENCY

Agency	*Total Expenditures Fiscal 1965*	*Estimated Retardation Expenditures Fiscal 1965*	*% of Total Expenditures for the Retarded*	*No. of Retarded Served*
Department of Mental Health . . .	$81,736,998	$27,220,540	33%	12,617

Includes the four state residential schools and North Reading Rehabilitation Center, serving 8,431 retardates at a cost of $18 million; Monson State Hospital serving 1,591 retardates at a cost of nearly $4 million; the state mental hospitals serving 1,398 retardates at a cost of $5 million; and 32 clinics and 29 preschool nurseries serving 1,197 retardates at a cost of $239,733.

Sources: Massachusetts Department of Mental Health.
Massachusetts Financial Report, Public Document 140, Fiscal 1965.

Agency	*Total Expenditures Fiscal 1965*	*Estimated Retardation Expenditures Fiscal 1965*	*% of Total Expenditures for the Retarded*	*No. of Retarded Served*
Department of Public Health . . .	$29,213,356	$4,382,003	15%	1,439

Includes the programs of the Division of Maternal and Child Health serving 389 retardates at a cost of $156,873; programs of Services for Crippled Children serving 1,050 retardates at a cost of $43,955. In addition to these direct service programs for the retarded, the Department of Public Health has many programs which are related to retardation. Commissioner Frechette estimates that 15% of all programs of the Department affect the retarded in the state. These programs include day care licensing, research, immunization, standards enforcement and the PKU (Phenylketonuria) and other metabolic disorders program. The PKU program involves the screening of about 110,000 newborns annually.

Sources: Massachusetts Department of Public Health.
Massachusetts Financial Report, Public Document 140, Fiscal 1965.

Agency	*Total Expenditures Fiscal 1965*	*Estimated Retardation Expenditures Fiscal 1965*	*% of Total Expenditures for the Retarded*	*No. of Retarded Served*
Division of Youth Service	$5,609,860	$729,282	13%	105

The number of retarded served represents youth testing below 80 I.Q. in 1964 at DYS Reception Centers in Boston, Worcester and Westfield. The number should be considered minimal since figures were not available for the Westfield Reception Center for Girls and Worcester Reception Center for Boys.

Sources: Division of Youth Service.
Massachusetts Financial Report, Public Document 140, Fiscal 1965.

Agency	*Total Expenditures Fiscal 1965*	*Estimated Retardation Expenditures Fiscal 1965*	*% of Total Expenditures for the Retarded*	*No. of Retarded Served*
Department of Correction	$15,570,990	$2,024,229	13%	499

The number of retarded served is based on the number of persons in state penal institutions testing below 80 I.Q.

Sources: Department of Correction.
Massachusetts Financial Report, Public Document 140, Fiscal 1965.

Expenditures for the Retarded and Numbers Served by State Agency (Continued)

Agency	*Total Expenditures Fiscal 1965*	*Estimated Retardation Expenditures Fiscal 1965*	*% of Total Expenditures for the Retarded*	*No. of Retarded Served*
Massachusetts Rehabilitation Commission .	$1,267,562	$139,432	11%	240

Number of retarded served is based on the number of retardates rehabilitated in fiscal 1965. Expenditures exclude federal funds.

Sources: Massachusetts Rehabilitation Commission.
Massachusetts Financial Report, Public Document 140, Fiscal 1965.

Agency	*Total Expenditures Fiscal 1965*	*Estimated Retardation Expenditures Fiscal 1965*	*% of Total Expenditures for the Retarded*	*No. of Retarded Served*
Department of Education	$49,842,443	$4,477,898	9%	12,763

Total expenditure excludes expenditures of the Division of Youth Service.

The retardation expenditure represents 50% reimbursement to school systems and local park departments for special classes and recreation programs for school age retarded persons.

Sources: Massachusetts Department of Education.
Massachusetts Financial Report, Public Document 140, Fiscal 1965.

Agency	*Total Expenditures Fiscal 1965*	*Estimated Retardation Expenditures Fiscal 1965*	*% of Total Expenditures for the Retarded*	*No. of Retarded Served*
Department of Public Welfare:				
Aid to Families with Dependent Children .	$19,648,859	$ 785,954	4%	3,945
Aid to the Permanently and Totally Disabled	10,229,899	1,534,485	15%	1,988
Division of Child Guardianship . . .	10,000,000	2,000,000	20%	1,780

The figure of 7,713 retarded served and the total retardation expenditure of $4,320,439 excludes retardates in other categorical assistance programs and on general relief. Also excluded are the federal share of welfare costs and the $1,500,000 spent by cities and towns for AFDC and APTD for the retarded in fiscal 1965. Figures for AFDC are based on 117 case records read in 15 sample towns and cities and presented in *Meeting the Problems of People in Massachusetts, A Study of the Massachusetts Public Welfare System, Table X, p. 20.*

Expenditures include cost of administration, as well as direct financial assistance.

Sources:

Massachusetts Department of Public Welfare.

Characteristics of Recipients of Aid to the Permanently and Totally Disabled, Findings of the 1962 Survey: National Totals, U. S. Department of Health, Education and Welfare, Welfare Administration, 1964, Table 21.

Meeting the Problems of People in Massachusetts, A Study of the Massachusetts Public Welfare System, National Study Service, sponsored by Massachusetts Committee on Children and Youth, and United Community Services of Metropolitan Boston, 1965, Tables I, II, III, p. 4–5.

ADMINISTRATION OF RETARDATION SERVICES

RECOMMENDATIONS

ESTABLISHMENT OF OFFICE OF RETARDATION

3. An Office of Retardation, responsible to the Governor, should be established to assume the responsibility for developing a coordinated interdepartmental approach to combat retardation. The initial operating budget of this Office should be approximately $100,000 per annum.

A PLANNING BOARD

4. A Planning Board to govern the Office of Retardation should be established consisting of the Commissioners of Mental Health, Education, Public Welfare, Public Health and the Executive Secretary of the Commonwealth Health and Welfare Commission as an ex-officio member. In addition, there should be representation from other governmental and private agencies concerned with retardation.

STAFF

5. Professional staff positions including a Director and Deputy Director should be established for the Office of Retardation.

LEGISLATIVE REVIEW

6. A special legislative commission should review the operations of the Office of Retardation to determine whether interdepartmental coordination and administration can be improved. This review should take place five years after the establishment of the Office of Retardation.

INTRADEPARTMENTAL COORDINATION

7. The position of Assistant Commissioner for Retardation should be established within the Departments of Education, Public Welfare and the Massachusetts Rehabilitation Commission and the position of Chief Retardation Coordinator within the Department of Public Health.

Correctional agencies should have a retardation specialist available to them from the staff of the Office of Retardation to assist them in coordination of retardation activities.

URGENT NEED FOR COORDINATION

A need for an effective interagency retardation planning body for Massachusetts is urgent and compelling. The very multitude of retardation programs and the number of different agencies having responsibility for serving the retarded make the need for coordination self evident. Programs run the gamut from screening newborns for phenylketonuria (PKU) to providing social services for retardates receiving old age assistance. Agencies contributing to the effort to aid the retarded include those not usually thought of as being involved with retardation, such as the Department of Natural Resources and the Department of Labor and Industries.

At least $50 million was expended in the fiscal 1965 by state agencies for services for the retarded. Approximately $30 million was expended by the Department of Mental Health; approximately $5 million by the Department of Education; approximately $4 million by the Department of Public Welfare; approximately $4 million by the Department of Public Health; and approximately $2 million by the Department of Correction. In addition the Division of Youth Service spent about $729,000 and the Massachusetts Rehabilitation Commission expended $139,432.

Recommendations of the Planning Project clearly indicate that these agencies, as well as others, will continue to share the expanding responsibility for providing retardation services (See Figure 1).

Currently no mechanism exists for the coordination of retardation inservice training programs; no plans exist for the integration of retardation activities within the forthcoming community mental health programs; no communications apparatus exists for disseminating reliable up-to-date information; research efforts go off in all directions and over-all long range retardation planning has not been the responsibility of any single department or agency.

More than 50 of the recommendations approved by the Planning Board of the Massachusetts Mental Retardation Planning Project reflect the need for an interdepartmental planning agency. Explicitly, or implicitly, these proposals point out the necessity of interdepartmental coordination and cooperation. Some examples follow:

The proposed Office of Retardation will encourage retardation research by administering the state retardation research fund; by conducting symposia on retardation research and by assisting universities, medical schools and hospitals to obtain research funds.

To adequately train personnel for their new jobs, the Office of Retardation will work with various state departments to develop appropriate inservice training programs for all agencies serving the retarded and their families.

An Office of Retardation will play a large role in stimulating effective vocational services for the retarded by working with the Massachusetts Rehabilitation Commission, Department of Mental Health, Department of Education, and Division of Employment Security to determine the adequacy of existing services and the appropriate role for each agency. In addition, the Office will collaborate with the relevant agencies to assure that adequate supportive services are available to retarded clients in workshops.

Furthermore, the Office of Retardation will assemble and disseminate departmental rules and regulations relating to retardation; will prepare a manual outlining standards for facilities, for personnel and for licensing arrangements for retardation programs.

A number of studies and research projects have been recommended to be undertaken by an Office of Retardation. These include: a study of the feasibility of establishing a Division of Adult Guardianship; a legal study of the status of persons with multiple disorders; a comprehensive study of the civil rights of institutionalized retarded persons; a study to determine the feasibility of establishing research units at Dever, Belchertown and Hathorne state residential schools; and a one-year study of the temporary certificate situation in regard to physicians and teachers.

FIGURE 1

RETARDATION — A MULTIDEPARTMENTAL RESPONSIBILITY

Recommendations of the Planning Project Classified by Governmental Unit Responsible for Implementation*

Recommendations by Subject Areas	*Governmental Unit*													
	Communications and Education Unit	Department of Correction	Department of Education and Local School Systems	Division of Employment Security	Health and Welfare Commission	Judiciary	Legislature***	Department of Mental Health	Department of Public Health	Department of Public Welfare	Rehabilitation Commission	Office of Retardation	Division of Youth Service	Other
Administration			1				4		1	1	1	1		
Community Services		5	6	6	1			18	8	8	6	3	6	2
Residential Programs							3	16						
Educational Programs			34				2	34			1			4
Vocational Training and Employment		4	4	4			1	5	1	3	7	6	4	1
Manpower		3	6	3			3	9	3	3	3	5	3	10
Law		3	2	1		14	23	12	2	5	2	1	2	1
Prevention		1	12	1	2		2	2	22	2	1		1	15
Research		5	5	5			1	6	6	5	5	6	5	3
Public and Professional Awareness	9	1	1	1	1		1	2	1	1	1	2	1	1
*Total***	9	22	71	21	4	14	40	104	44	28	27	24	22	37

*This classification is not intended to reflect relative significance of departments in retardation activities. Rather, the emphasis is on portraying the multidisciplinary and interdepartmental scope of the conclusions of the Project. For example, only 14 recommendations are classified within the responsibility of the courts, yet the text on law clearly indicates that safeguarding the civil rights of the retarded is a major issue of public policy affecting many individuals.

**Many recommendations are directed to more than one agency; therefore the totals exceed the number of recommendations in the report.

***Includes only those recommendations which call for specific legislative enactment or specific appropriation. Implementation of all recommendations, of course, requires legislative support.

Examples noted above represent a few proposed functions for an Office of Retardation. The Office will have a significant role in implementing all recommendations which call for interdepartmental collaboration and interagency coordination.

An Office of Retardation will provide a framework for assuring continued progress in preventing retardation and serving those already afflicted. Changes in conditions, resources and priorities, coupled with advances in our knowledge about retardation, will require continuing evaluation of programs and services.

Recommendations and findings of the current temporary Planning Project should be updated and periodically reassessed by a permanent planning unit, which can continue to give advice, stimulation to departments and agencies, and help in the coordination of vital programs.

OFFICE OF RETARDATION

Many alternatives were examined before reaching a decision on the type of administrative structure which should be created to implement the goal of coordination. It is recommended that an Office of Retardation be established as an independent executive agency directly under the Governor or within, but not subject to the control of, the Department of Mental Health.

The Office of Retardation will in no way be competitive with existing departments or legislative commissions. Much of the progress this Commonwealth has made in the field of retardation in the last 14 years can be attributed to the Special Legislative Commission on Retarded Children. However, coordination is an executive responsibility and requires an executive agency. Even if the legislature provides all the

concerned departments with all the necessary resources, these resources must be utilized to create a balanced and comprehensive array of services. This requires effective interdepartmental communication and active cooperation which can be brought about only with the assistance of a permanent independent executive agency.

To achieve an interdepartmental approach and to promote the continuity of services, the Office of Retardation should have responsibility for:

- Developing, reevaluating and keeping up-to-date a state plan for the coordination and implementation of programs for the retarded.
- Coordinating and planning professional training, recruitment, and placement procedures.
- Recommending standards for services for the retarded.
- Recommending a system of uniform record keeping to be used by agencies serving the retarded.
- Conducting studies and research programs concerning all aspects of retardation and retardation programs.
- Developing and submitting applications to the federal government for grants in retardation; assisting state agencies to do the same, and encouraging research through disbursement of research funds.
- Assisting all departments, divisions or subdivisions of the Commonwealth in improving their programs and services for the retarded.

PLANNING BOARD

In view of the many agencies and departments involved in retardation activities, a Board should be established to govern the Office of Retardation. The Board should serve as a vehicle for interaction among the various departments and assist in determining the policies of the Office of Retardation.

Membership of the Board should include all interested agencies and groups and at the same time keep the size of the Board down to manageable proportions. To achieve these goals, a 12 member Board is recommended. The Board should include the Commissioners of Mental Health, Public Health, Public Welfare and Education, the Executive Secretary of the Health and Welfare Commission and five persons appointed by the Governor. Another member should represent the correctional and youth service agencies and the last member should represent rehabilitation and employment security.

Permanent members of the Board should include the four Commissioners and the Executive Secretary. Of the five gubernatorial appointees, at least three should represent consumers of the services for the retarded. Another appointment should be a person not necessarily representing any organization or agency. These four should be appointed for five year terms.

The last gubernatorial appointment should be an official of state government representing the executive branch and serve at the pleasure of the Governor. One of the reasons for including the last member is to enhance the opportunities for close communications between the Office of Retardation and the Chief Executive.

The remaining two members should represent functional units rather than specific departments. One member should be appointed jointly by the Commissioner of Correction; the Director of the Division of Youth Service; the Chairman of the Parole Board and the Commissioner of Probation. The other member should be appointed jointly by the Commissioner of Rehabilitation and the Director of the Division of Employment Security. Both of these joint appointments should be for a one year term.

Power to appoint is given to the agencies jointly. They can set up a rotating appointing authority or delegate the authority to one of the group. Under this method each group is allowed the flexibility to work out the arrangement by which it can best achieve effective representation.

The chairman of the Board should be appointed by and serve at the pleasure of the Governor.

STAFF

An adequate professional staff should be employed to carry out the complex and variegated functions of the Office of Retardation. Staff should include a Director, Deputy Director, and five Associates plus adequate clerical services.

The Board should appoint the Director of the Office of Retardation to assume administrative responsibility for the Office. The Deputy Director should be appointed by the Director.

Both the Director and Deputy Director should have substantial training and experience in the planning or administration of programs in health, welfare, education or other related areas. They should have demonstrated competence to undertake responsibility for retardation planning by at least four years of experience in positions of administrative responsibility in health, welfare or educational programs and at least a master's degree in the related areas. If possible, they should have a working familiarity with programs for the retarded. Both the Director and Deputy Director should be exempt from civil service requirements.

Either the Director or Deputy Director should be qualified to supervise projects involving program development, operational research and statistical analysis.

Planning Associates should have the experience and the educational background to execute inservice training programs, coordinate research and assist other departments and agencies in providing more efficient services for the retarded. One Planning Associate should be assigned to assist correctional agencies to coordinate retardation programs.

In addition, adequate clerical services should be included to assure that the mechanics will not bog down.

LEGISLATIVE REVIEW

Major changes are occurring in the health and welfare fields. Many of these changes could influence the direction of retardation programs. To keep the program and policies of the Office of Retardation in tune, a special legislative commission should review the organization structure of the Office five years after its establishment.

Although the Planning Project was primarily concerned with the problems of coordination in the area of retardation, the importance of promoting over-all efficiency and sound management of the executive branch of government should not be overlooked. Therefore, if current proposals for administrative coordination in the health-welfare field are amended or if future innovations lead to the development of a structure which could support a retardation unit, the Office of Retardation could be accommodated within the framework of the broader coordinating mechanism.

On June 7, 1966, Governor Volpe signed into law a bill sponsored by Senate President Donahue for the creation of a Health and Welfare Commission to plan, coordinate and develop comprehensive programs in the areas of health and welfare. This Commission consists of the Commissioners of Public Health, Mental Health, Welfare and Rehabilitation and three gubernatorial appointees.

While the principle of coordination is heartily endorsed, the Health and Welfare Commission established by Chapter 353, Acts of 1966 does not include the Department of Education or correction agencies. It is clear that these agencies which are currently spending more than seven million dollars on behalf of the retarded cannot be ignored if we are to have meaningful planning and coordination.

AMENDMENT NEEDED

On April 12, 1966 Governor Volpe signed into law a bill introduced by Representative Brett, authorizing the establishment of an interagency council on mental retardation. Although the intent of this legislation is laudable, it falls short of meeting the need for an effective coordinating body. The act establishing the council fails to provide for staff, fails to specify functions and is deficient in composition of membership. The only responsibility of the council under C. 160, Acts of 1966 is to recommend legislation to the Governor and the General Court. However, this function is already being carried out quite adequately by the Special Legislative Commission on Retarded Children under the Chairmanship of Senator Joseph D. Ward. Omission of representatives of the Department of Public Welfare, the correctional agencies and nongovernmental interests constitutes a serious defect and the clause providing that the Commissioner of Mental Health serve as Chairman negates the concept of independence which is essential to achieving effective coordination and planning.

Therefore, it is suggested that C. 160, Acts of 1966 be amended to conform to the structure and functions of the proposed Office of Retardation.

INTRADEPARTMENTAL COORDINATION

Assistant Commissioners in the Departments of Public Welfare, Education and Rehabilitation should be appointed to supervise, plan and advise on all programs conducted by their departments relating to retardation. A chief coordinator for retardation programs in the Department of Public Health should be designated to fulfill similar responsibilities in that Department. The experience of the Department of Mental Health since the establishment of the position of Assistant Commissioner for Retardation points to the value of having a high level specialist in each department with responsibility for coordinating retardation activities. Departmental staff will provide a focus for retardation programs and work closely with staff members from the proposed Office of Retardation.

DEPARTMENT OF PUBLIC WELFARE

The position of Assistant Commissioner for Retardation should be established within the Department of Welfare. Serving directly under the Commissioner, the person in this position should be responsible for supervising, planning and coordinating the various programs as they relate to the retarded within the Division of Child Guardianship and the Division of Public Assistance. In addition to the general responsibility for coordination of retardation services, the Assistant Commissioner should be responsible for defining the scope of the department's programs, evaluating these programs as they relate to the retarded and developing new programs.

Through its child welfare programs and public assistance activities, the Department of Public Welfare serves a significant number of retardates. Any increase in the department's effectiveness in regard to its retarded clients will have an impact on the effectiveness of the entire department. There are many areas where high level staff assistance is needed. For example, the Assistant Commissioner could work toward developing an administrative plan under the Aid to Families of Dependent Children program to furnish day care, homemaker services and other social services to the families with retarded children. Presently, there is no operational program which takes into account the complex problems of providing services to families with retarded members.

The Assistant Commissioner could also play an important role in assisting the Division of Child Guardianship staff in expanding the present effort to provide foster care for retarded children. One reason for the slow development of this program is lack of staff to devote sufficient time to the project.

MASSACHUSETTS REHABILITATION COMMISSION

A position of Assistant Commissioner for Retardation Services should be established within the Massachusetts Rehabilitation Commission. The Rehabilitation Commission must meet an increasing obligation to serve the retarded. The Vocational Rehabilitation Amendments passed by the Congress in 1965 call for new directions in rehabilitation programming which will provide more opportunities for the retarded. This will require the Massachusetts Rehabilitation Commission to expand its present emphasis on rehabilitation of persons for independent gainful employment to rehabilitation of those persons who may have less potential than those now being served. An Assistant Commissioner for Retardation Services is necessary to plan and supervise new rehabilitation programs for the retarded.

Planning and coordinating rehabilitation services for the retarded involves the development of adequate intradepartmental communications, broad areas for program development, inservice training and other activities relating to retardation.

The challenge and complexities of an expanded emphasis upon prevocational programs and longer periods of sheltered employment for those unable to compete independently in the labor market, underlie the importance of creating this new top level position.

The quality of rehabilitation services extended to the retarded depends greatly on the rehabilitation counselor and the resources available to him. Among the counselors' many functions and responsibilities falls the duty of determining the eligibility of the applicant for rehabilitation services. This determination requires not only an evaluation of the applicants' disability, but a knowledge of the rehabilitation resources and opportunities within the area. The Assistant Commissioner could provide a valuable service by channeling information on opportunities for the retarded to each of the district offices and to the counselors.

This new focus in the Commission will necessitate gathering and analyzing service data on retarded clients and other information necessary for program evaluation.

Effective programs for the rehabilitation of retarded persons have been supported at the district office level of the Massachusetts Rehabilitation Commission. Examples are the Leominster training program in die polishing for retarded boys and the nursing home training program in Greenfield for retarded girls. Although these programs are small and limited in scope, both have been successful in accomplishing the objective of training and placing the retarded. The establishment of this new position would increase the efficiency of the Massachusetts Rehabilitation Commission by serving as a channel through which information and experiences concerning the retarded could flow. In this way, innovations in

one district could be quickly translated into action programs in the other districts.

Another important responsibility of the Assistant Commissioner for Retardation Services should be interdepartmental communication. The task of rehabilitating a retardate requires close cooperation among the educational, employment and rehabilitation agencies. The Assistant Commissioner should have the responsibility of maintaining a continuing dialogue with the staff of the Division of Special Education, obtaining information on the retarded in special classes, the extent of inschool vocational services and other activities in special education. The coordinator should also communicate with local school officials, staff of the mental health facilities, and staff of the Division of Employment Security in regard to the services available for the retarded from the Massachusetts Rehabilitation Commission. It should be noted that the Massachusetts Rehabilitation Commission and the Division of Employment Security have a cooperative agreement, establishing a working relationship between the two agencies in providing service to handicapped persons. The Assistant Commissioner could make use of the existing formal arrangement to bring about maximum service to the retarded in the areas of rehabilitation and placement.

DEPARTMENT OF PUBLIC HEALTH

A Chief Coordinator of Retardation Programs should be designated by the Commissioner of Public Health. The Coordinator will be located within the Division of Health Services, but will have the responsibility for the coordination of all departmental programs and policies relating to retardation. In addition to the direct services provided to retardates by the Department, through the Division of Maternal and Child Health, and Services to Crippled Children, the Department has many programs which are of utmost importance for the prevention of retardation. Activities of the Diagnostic Laboratories, Biologic Laboratories, Division of Communicable Diseases, and the Division of Food and Drugs, all have important implications for the prevention of retardation. Although many programs such as the inspection of diagnostic x-ray equipment and hospital licensing, have only an incidental effect on prevention, the improvement and coordination of these programs can have a vital impact on the over-all prevention effort. The Coordinator should be responsible for insuring that all divisions and subdivisions are kept aware of the relationship of their activities to retardation.

The Coordinator should work to facilitate interchange of ideas and information among the Department's four district health offices and develop a degree of uniformity of services for the retarded within each district.

The Coordinator should also have an interdepartmental role providing links to other retardation coordinators, the Department of Mental Health and the interagency retardation body. For example, a specific task of the Coordinator could be a study of the feasibility of expanding orthopedic services presently provided by the Department of Public Health at Lakeville to residents of state residential schools for the retarded.

Functions of the Coordinator will take on more importance as the Department of Public Health's role in retardation takes on greater significance with the development of genetic counselling, prenatal care, and other public health preventive programs.

DEPARTMENT OF EDUCATION

A position of Assistant Commissioner for Retardation should be established within the Department of Education to supervise, direct, and coordinate the programs providing education for the retarded in Massachusetts. The role of education in making the lives of the retarded more creative and worthwhile has long been recognized by the Commonwealth. Since the latter part of the nineteenth century, the state has pioneered in the field of special education for the retarded.

Since 1954 these programs were supervised by the Division of Special Education. Under the recent departmental reorganization, the Division of Special Education was abolished and its functions transferred to one of a number of bureaus to be supervised by a single assistant commissioner.

The value of specialization at the top administrative level has been successfully demonstrated by the progress made by the Department of Mental Health's Division of Mental Retardation, headed by an assistant commissioner in that department. The Education Department's responsibility for updating and supervising the more than 600 special classes for some 45,000 retarded children also requires an assistant commissioner to provide the same level of administrative direction.

The Assistant Commissioner for Retardation should be responsible for the initiation and development of a variety of education programs including the responsibility of seeing that local schools comply with the standards for programs of special education, including those recommended by the Planning Project; the direction of the expansion of regional special education classes to provide for educating the retarded in the 50 communities that presently have no program and the development of curriculum guidelines, teaching aids and equipment, so local schools can benefit from recent advances in the field of teaching the retarded.

Interdepartmental coordination of programs would lead to increased exchanges of ideas and methods with other agencies. This would be especially true of cooperation with staff in the Department of Mental Health and with the proposed Office of Retardation. In addition, ongoing cooperative programs between schools and the Massachusetts Rehabilitation Commission and the Division of Employment Security should be established under the supervision of the Assistant Commissioner for Retardation to help insure that vocational help or employment awaits a retarded youngster upon graduation.

Being large and ever expanding, the role of the Department of Education in the area of retardation requires high level direction and guidance if programs are to be most effective.

A COMMUNITY SERVICES NETWORK FOR THE RETARDED

RECOMMENDATIONS

LOCAL ACCESSIBILITY

8. To assure that services for the retarded are accessible locally, programs should be comprehensive and should serve local areas of approximately 75,000 to 200,000 people, as set forth in the Massachusetts Mental Retardation Facilities Construction Program under Public Law 88-164, Title I, Part C.

COMPREHENSIVE AND COORDINATED SERVICES

9. A comprehensive array of coordinated services, including formal and informal arrangements among public and voluntary facilities, should be contained in an area's retardation program to assure continuity and ease of accessibility to needed services.

CONTRACT AND FEE FOR SERVICE ARRANGEMENTS

10. To assure that necessary services are provided in each area of the Commonwealth, contract and fee for service arrangements should be encouraged with the flexible use of public and private funds.

SERVICE ELEMENTS

11. A comprehensive community retardation program must be accessible, assure continuity of care, and include, but not be limited to, at least eight essential elements: preventive, diagnostic, and evaluation services; treatment services, training services, educational services, personal care services, prevocational, vocational, recreational, and other leisure time services.

CENTERS AS FIXED POINTS OF REFERRALS

12. Retardation centers should be established in each of the 37 local areas. Centers should be designated as the fixed points of referral for each area through which the retarded and their families can depend on continuing lifetime guidance and assistance in obtaining needed services.

AVAILABILITY OF ALL RELEVANT SERVICES IN AREA PROGRAMS

13. All health, education, welfare and recreational services in each area should be available to retarded persons. These should be augmented by specialized services, many of which would be provided by area retardation centers. All these services should be components of the area retardation program.

EARLY IDENTIFICATION

14. Early identification and case finding services should be developed by each area retardation center. Appropriate inofrmation and consultation should be provided to community caregivers, such as obstetricians, pediatricians and the clergy, and by developing collaboration and subcontract arrangements with agencies such as public health nursing or social work agencies.

HOME TRAINING

15. Home training services should be incorporated into retardation programs and should include collaboration with public and voluntary health, education and social service home visiting programs.

FAMILY COUNSELLING

16. Individual and group counseling with parents and families of retarded children should be an integral part of all programs providing services for the retarded.

ALTERNATIVES TO INSTITUTIONALIZATION

17. Foster care and group home arrangements should be used as alternatives to institutionalization for retarded children when care in their own homes is not practical or possible. Existing foster family services should be used to capacity, especially for preschool and younger school age children. Small group home facilities should be encouraged under non-profit auspices, especially for older school age children.

DIAGNOSIS AND EVALUATION

18. Diagnosis and evaluation services should be available in each area. These should include medical, psychological and social services, supplemented, when appropriate, by nursing, educational and vocational services, all of which should be carried out under qualified supervision.

Referral to more specialized and extensive diagnostic and evaluation services should originate from area comprehensive centers.

DAY CARE FOR SEVERELY RETARDED

19. Each mental health-retardation area should establish a day care program for severely retarded school age children who are not eligible or who are otherwise unable to participate in trainable classes for the retarded.

COMMUNITY GROUP HOMES FOR INDEPENDENT LIVING

20. The Department of Mental Health should investigate the development of community group homes for adult retardates who can benefit from independent living with minimal supervision.

RECOMMENDATIONS

HALFWAY HOUSES

21. Halfway houses should be utilized for residents to help them make the transition between sheltered institutional settings and more independent community living where clinically feasible and appropriate.

ADULT COLONIES

22. Adult "colonies" providing semiindependent living arrangements for retarded adults, who do not require intensive medical and nursing care should be developed by the Department of Mental Health.

NURSING AND REST HOMES

23. Program and facility guidelines for nursing homes and rest homes for adult and older adult retardates should be developed cooperatively by the Department of Mental Health and Public Health.

MANUAL OF STANDARDS

24. A manual outlining standards for services, personnel and licensing requirements of retardation programs run directly by state agencies, or by contract and fee for service arrangements through other agencies, should be published and kept current by the proposed Office of Retardation.

RESEARCH

25. An active research program stressing operational and program evaluation should be a component of community services for the retarded.

SERVICES FOR THE RETARDED

In view of the increased nationwide attention to find alternative methods to institutionalizing the retarded, major efforts must be made to develop the necessary supporting services at the local level. Many of the services considered essential for providing a continuum of care throughout the life span of a retarded person are, in many communities, either not available, or only available for clients with other problems. What conditions are necessary to provide a comprehensive local retardation program available to all residents?

Until recently, the major emphases emanating from state agencies for the provision of services to the retarded have been schooling (in the form of special classes) and institutionally based programs in the state residential schools for the retarded. In more recent years other community based services developed through programs of a specialized nature and through existing "generic" programs which have increased their commitment to serving the retarded.

In the inventory of services for the retarded undertaken by the Planning Project, a total of 164 specialized and 386 generic agencies serving the retarded were identified. These agencies served approximately 35,000 retarded individuals during 1965. Projections, based on available samples of those retardates served by agencies not included in the inventory, would indicate that the number of those identified as falling into the retarded grouping who received health, education and welfare services in Massachusetts during 1965 would be in the area of 50,000 or approximately 1% of the state's population. This finding is consistent with similar attempts by other states to identify those among the retarded who are actually receiving services.

Of those served by agencies which specialize in services for the retarded, approximately 38% were found to be either severely or profoundly retarded. An additional 24% were found to be moderately retarded, and the remainder to be mildly retarded. A generally accepted "rule of thumb" for those engaged in the planning of services for the retarded is that two to three times as many individuals afflicted by retardation reside in the community and are in need of some form of services as compared to those who are actually receiving services.

About 8% of the projected retarded population is now receiving services in a public or private institution. The remainder are residing in the cities and towns of the Commonwealth. They must rely on the services available at the community level for helping them and their families receive needed support and care.

At least two basic questions must be addressed when considering the ingredients for a comprehensive community retardation program: For whom are the services to be provided? What range of services will the facilities and agencies provide? In answer to the first question, any program making use of public funds cannot establish arbitrary service criteria, such as restrictions on age, financial ability, race or religion, diagnostic catogery or minimal residential requirements. Services must be available to all. A related aspect of this first question is the problem of how to define the character and size of the community to be served by a specific retardation program. In accordance with population guidelines developed by the federal government, the state has been divided into 37 areas, most ranging from 75,000 to 200,000 in population.

Principal criteria for service area boundaries include accessibility, the development of a full range of services, and the possibility of building on existing services. Community diagnostic-evaluation and day services should be planned within one hour's drive by any resident of Massachusetts to an appropriate facility. The services should be available in each of the state's 37 areas. Service areas should be coordinated with those of mental health programs. Service lines of other state agencies should also be taken into account, as well as the boundaries of standard metropolitan statistical areas, existing or proposed limited access highways and physical proximity to urban centers. It should be made clear that specific boundary lines for retardation programs are not intended to prevent a facility from accepting clients outside this area if it wishes to do so, and if the client also desires such an arrangement. Some decisions will remain the prerogative of the individual facility. However, setting specific boundary lines should insure that each retardation program accepts the responsibility for providing necessary services to all citizens residing in the area.

Politically, the state is divided into 14 counties which vary considerably in size and population. Currently, the counties have little governmental authority or function since these

responsibilities reside in the state or with the 39 cities and 312 towns of the Commonwealth. Consequently, in planning for retardation services, it is not the formal county system which assumes importance, but rather the network of formal and informal community liaison which have developed throughout the state. Both the service areas and the larger regions of which they are a part should be subject to annual review. Boundaries should not be regarded as fixed and unchangeable.

What services should be provided in a community program? For a program to be considered comprehensive, it must include the six essential elements described in the federal regulations for a comprehensive community program for the retarded: diagnostic and evaluation services, treatment services, training services, educational services, personal care services and vocational services. In addition to these basic six services, prevention, recreation, and other leisure time services should be included. These elements should be available through accessible diagnostic and evaluation services, day services and long and short term residential facilities.

A COMPREHENSIVE ARRAY OF COORDINATED SERVICES

At least three principles must be closely adhered to for the development of an array of services for the retarded. First, needed services should be accessible. In particular, services provided on a daily basis over extended time should not be more than normal commuting distance. Day programs, sheltered workshops, and special classes in particular, should be located as close as possible to individuals requiring these services. Secondly, community services should be comprehensive in scope. They should include a variety of specialized and generic services needed at any one time, and throughout the life span of the retarded, and their families. Thirdly, since a variety of services will be necessary for catering to the total needs of the retarded person, these services should be coordinated on his behalf to assure their comprehensiveness and continuity. An important step toward the effective coordination of retardation services should be the establishment of centers to be designated as fixed points of referral in each area through which the retarded and their families can depend upon lifetime guidance and assistance in obtaining needed services.

At least three statewide developments will help to provide the structure under which these principles can be implemented. The pending reorganization of the Department of Mental Health includes the establishment of 37 mental health-retardation service areas throughout the Commonwealth. Each of these areas will have combined mental health retardation boards as well as a special retardation advisory committee. Area boards and staff assigned to these areas are mandated to look at the total service needs of the retarded residing within these areas. This would include the provision of services by public and voluntary facilities and their interrelation through formal and informal arrangements. A Health and Welfare Commission, recently established by the legislature, will be studying among other things, the best methods for coordinating health and welfare services which should include the delivery of such services on the local level.

A major recommendation of the Planning Project is the establishment of an Office of Retardation which will stimulate the redirection and coordination of local services on behalf of the retarded.

If a real partnership is to be established between public and voluntary service givers and if flexibility in programming is to be achieved, the Department of Mental Health and other Commonwealth agencies should be encouraged to enter into contracts and fee for service arrangements. The Commonwealth should be primarily concerned with seeing that necessary services are provided. The issue of whether the services are to be provided by a public or nonprofit agency should be secondary to the adequacy and appropriateness of the service.

ESSENTIAL PRINCIPLES IN THE DEVELOPMENT OF COMMUNITY SERVICES

Some differences will no doubt continue to exist about the central emphasis and precise functions of a community retardation program. However, there is current agreement that the following principles must be included in the framework of any program:

- The retarded and their families must be the focus of any program designated to meet their needs. Clients should not be required to fit the institutional needs of agencies and services in order to receive help.
- Agencies should be flexible enough to accommodate a variety of problems. If an agency cannot extend a particular service, it should take responsibility for followup, and referral to other community agencies, where the appropriate service or services can be provided. However, if the service needed does not exist, the agency should assume the responsibility for bringing this gap to the attention of the area retardation board.
- Attempts should be made to sustain the retarded in their own community setting.

Only in difficult and unusual circumstances should long term institutionalization be sought. Social scientists have conducted many studies in recent years indicating that social ties and family surroundings, especially in the early years, are crucial to subsequent development for most individuals. These ties are especially crucial for those afflicted with retardation.

Parents should be encouraged and helped to accept their retarded family member within the family matrix. In situations where this arrangement is found to be undesirable for the physical and psychological health of the retardate or his family, foster care arrangements should be sought which approximate the nuclear family environment. Aside from the intrinsic value of foster home arrangements, continued care facilities in regional residential centers are currently overcrowded with more than 900 on waiting lists throughout the Commonwealth. Dr. Walter E. Fernald, Massachusetts' pioneer in the administration of residential centers for the retarded became convinced more than 40 years ago that parents should be helped to maintain retarded children at home if they were able to provide for their care. Dr. Fernald maintained that only children with severe physical and mental disabilities required institutional care. Continuity of services, or in the nomenclature of the President's Panel on Mental Retardation, "continuum of care," must be provided if the retarded are to be effectively sustained in the community.

Especially important are efforts to enable the retarded and their family to bridge the transition points between established services. Thus, well trained and sensitive professionals must help families to make meaningful arrangements between home training and preschool programs; between preschool and school programs; between school and habilitation programs and between habilitation and employment or sheltered workshops or other adult activity programs.

STRUCTURAL REORGANIZATION FOR THE DELIVERY OF COMPREHENSIVE SERVICES

The needs of the retarded are, at a minimum, the needs of all other individuals in the population. Community services available to all persons should also be available to the retarded. In addition to these general or "generic" services, specialized services of various kinds are necessary for the disabilities commonly associated with retardation.

At the community level, the problems of the retarded are not, and cannot be, the responsibility of only one agency. A partnership between generic and specialized agencies must be culminated before the retarded can participate in a truly comprehensive community program. Therefore, the Planning Project has developed an approach for each retardation area which begins with a mandate for the development of an areawide program. The program concept which is encompassed in the new Massachusetts mental health-retardation legislation stresses the ingredients necessary for a total array of services which could be accessible and available to all the retarded and their families. An area program is not limited to a local unit of a state department, to any other single public agency or to any voluntary agency or association; it includes all legitimate services, facilities and care givers, regardless of auspice. Under provisions in the new act establishing a comprehensive program of mental health and retardation services, the area board must be involved in the establishment of program priorities for the area, in policies regarding relations with other agencies and organizations. The area board exercises prior approval of arrangements and contracts for programs and services which are not conducted within Commonwealth operated facilities.

A representative group of citizens and the area director and his staff in each area will therefore exercise major responsibilities for overseeing and helping to assume a comprehensive approach to the provision of generic and specialized services for the retarded. Area boards, however, will need assistance in seeing that other state agencies as well as other public and voluntary local agencies do indeed participate in an area's program. The proposed state Office of Retardation will assist area boards in developing an inclusive and truly comprehensive approach to the provision of services for the retarded in each area.

PROCEDURAL REORGANIZATION

Forthcoming legislation, emanating from the activities of the Project's Task Force on Law, the Special Legislative Commission on Mental Health and the Boston University Law-Medicine Institute, will revise and modernize the General Laws of the Commonwealth to provide explicit and flexible procedures for the care of the retarded. All relevant health, education and welfare departments with the stimulation of the proposed Office of Retardation will be charged to budget, approve and promulgate new rules and regulations in a number of important areas.

These proposals will establish standards for identifying those in need of specialized assistance, will establish procedures for comprehensive evaluation and reevaluation and will provide that relevant agencies annually file reports with the Office of Retardation concerning their activities, programs and services for the retarded.

Through these procedural changes the Office of Retardation will be better equipped to identify service gaps and give assistance to service areas in the provision of comprehensive services and other coordination.

SERVICES IN THE EARLY YEARS

Early identification of suspected retardation is important because of the necessity of making a correct diagnosis and of promptly introducing the first of what may be a lifetime of special services. Many physicians believe that residential care is the only alternative for the retarded child and that such a plan is best for the family. In the great majority of cases, institutionalization is very harmful to the child and leaves the family with a heavy burden of guilt. The more specialized information that can be made available to physicians, clergymen and other professionals and the more special services that can be offered to help their patients, the greater should be their willingness to recommend home and community care for the young retarded child.

It is extremely important that the retarded be identified at an early age. Their characteristics and needs must be understood early and programs designed to promote optimum development in the physical and psychological areas. The earlier a handicapping condition is detected, the greater the possibilities for preventing further deleterious effects and remedying those effects which are present.

HOME TRAINING

Area retardation programs should plan for home training services emanating from comprehensive mental health and retardation centers. This program should include collaboration and cooperation with analogous public health, public education, and private service agency home visiting services.

A home training service should assist parents to develop an objective approach to everday problems presented by the child. The service should develop adequate home training and care techniques, should acquaint parents with all available community resources, and provide direct training for the child.

This program would serve primarily the severely retarded who potentially will be able to develop only limited degrees of self-help and socialization skills. Where preschool nursery clinics, day care programs and public school programs can be used, the program would be an adjunct resource.

The Massachusetts Department of Mental Health, through its preschool nursery clinic program, has been conducting a small pilot study of home training services which will be somewhat expanded in 1967. A trained nursery school teacher has visited the homes of retarded children too young or too handicapped for a regular nursery experience. Mothers have been given not only comfort and support but techniques and suggestions for stimulating and facilitating the development of their child. They have also been given, at a crucial time for them, the encouragement and hope that there are programs in the community for retarded children. Future expansion of this program will explore the contributions of other workers, such as social workers, public health nurses and physiotherapists. Such programs should be related to clinical services which can help the home visitors to handle or refer emotional crises which may arise.

DIAGNOSTIC AND RELATED COUNSELLING SERVICES

Diagnostic and related counselling services for the retarded and parents are presently provided by a number of different sources representing a variety of professional disciplines as well as numerous state and community agencies, both private and public.

In the inventory of services to the retarded recently completed by the Planning Project, diagnostic services were

defined as including medical, psychological and social services, supplemented where appropriate by nursing, educational and vocational services and carried out under qualified supervision. The components of the diagnostic and evaluation process include assessing the strengths, skills, attitudes and potentials for improvement of the individual; determining personal and family needs; determining a specific plan of services with necessary counselling to carry out recommendations and providing periodic reassessment of progress. Included in the process, where appropriate, are speech, occupational and physical therapies as well as case consultation services.

Although the need for parent and family counselling seems so obvious, it is so often overlooked. For the most part, parents of the retarded do not require long term psychotherapy. They do need group counselling with a heavy emphasis upon practical management, support, and encouragement. Specialized professional help should be readily available when short term crises arise or when more intensive therapy is required. Provisions must also be made for counselling the siblings of retarded children who face special stresses in understanding the retarded brother or sister.

Total community resources can be grouped into the following categories:

- Physicians, psychologists, and other specialists in private practice.
- Services of the public school system including psychological services and special education and services of employment and vocational rehabilitation agencies.
- Comprehensive child guidance centers and mental hygiene clinics.
- General clinic services offered by universities and hospitals. These may be concerned only with specialized aspects of comprehensive diagnosis and treatment of retardation.
- Specialized clinics for the handicapped or for the retarded specifically. In Massachusetts, each state residential school for the retarded is developing an Evaluation-Rehabilitation Clinic. A central clinic is currently under consideration for the Boston or Worcester area.
- Public clinics operated by official health departments, such as: Well baby and prenatal-postnatal clinics.
- Special programs of "intervention," such as the War on Poverty, which promote services designed to reach people not ordinarily in the mainstream of community service.

In addition, a variety of public and private agencies provide limited case work or counselling services. The relations of these agencies with diagnostic facilities are frequently limited or absent. A majority of these resources do not offer complete diagnostic, treatment, and parent counselling services. Rather, most are concerned with only a limited aspect of the total need, each providing a somewhat different emphasis. For example, the diagnostic services of a school system may be concerned chiefly with whether, or not, a given child is retarded intellectually, and needs to be placed in a special class.

A pediatrician may be concerned mainly with the medical etiology of the handicap and conditions needing medical treatment, and may have only limited interest in planning for the long term care and training of the child.

Of the 164 organizations surveyed by the Planning Project which offered specialized services to the retarded, 65 included evaluative and diagnostic programs. As would be expected, rural areas of the state lack the substantial accessibility to the services more readily available in the densely populated urban areas.

In the 34 clinics operated by the Department of Mental Health, child psychiatrists, case workers and psychologists form teams competent to conduct evaluations of retarded children. These teams are able to furnish many therapeutic and supportive services to children and their parents. Based on the experience of the recently established comprehensive retardation centers in Worcester and Quincy, the Department plans the institution of two new comprehensive centers a year, in addition to the major complexes under construction in Lowell and Fall River. Supportive training, habilitation, parent counselling, day care, and short term residential services should buttress the core diagnostic and evaluative services offered, and open up these services further to all age groups.

As they are established in each area, comprehensive retardation centers should provide core diagnostic and counselling services. The retarded and their families should be able to count upon these centers for lifetime guidance and support.

DAY CARE FOR THE SEVERELY RETARDED

The Department of Mental Health should establish day care programs for the severely retarded school age children residing in the community who are not eligible, or otherwise unable, to participate in trainable classes for the retarded. Provisions should be made for about 30 children in each service area at an estimated cost of approximately $50,000 for each of the 37 areas.

Many severely retarded children of school age can not be accommodated in trainable classes because they are not toilet trained, lack speech, or have restricting physical disabilities. Families of these children must have some help if they are to maintain their children at home. One of the major service gaps in Massachusetts is lack of a day care program for such individuals. Day care programs could operate from 9 A.M. to 3:30 P.M., provide self help training, recreation and stimulation for the retarded child and/or adult, and a necessary respite for the mother who is, otherwise, the constant caregiver.

FOSTER HOMES AND OTHER COMMUNITY ALTERNATIVES TO INSTITUTIONALIZATION

For many years in many states (including Massachusetts) too many children have been institutionalized in state residential schools because of the lack of available foster care services in the community. The fact of retardation, often quite mild, may be an excuse, not a reason, for shipping a child off to a large institution. The lack of appropriate emotional and social support in the institution often contributed to the disabling of the child which was then attributed to his inherent disability, his retardation. This kind of self-fulfilling prophecy has a perpetuating and circular effect. Unless places are created in the community for those children needing protective residential care, but not requiring constant medical and nurse care, we may be dooming them to a lifetime of institutionalization. In addition, the overcrowding of the state schools may deprive the more handicapped of adequate and appropriate care.

At the present time, the Division of Child Guardianship, State Department of Public Welfare supports and supervises a considerable number of retardates in its case load. A small number (11 in 1963) were discharged to state residential schools for the retarded. Currently, the Division is develop-

ing a cooperative program with the Worcester Area Comprehensive Care Center for the Retarded.

At the other side of the age spectrum, community placements to nursing homes have commenced as part of a stepped up program by state residential schools for the retarded. Program and facility guidelines need to be developed for nursing and rest homes for adults, and particularly, elderly retardates, to insure proper care and treatment. Such guidelines should be prepared cooperatively by the Department of Public Health and Mental Health.

Community placements for institutionalized retardates of all ages have run into serious obstacles. Social service departments at state schools are understaffed. Linkages with community placement agencies are nonexistent, or slow, because of intricate procedures. Perhaps most importantly, community based facilities have not adequately catered to the needs of the previous residents of the state schools. These facilities do not adequately serve the retardate living in the community who may eventually enter a state institution because he has no other alternatives.

Residential alternatives to the large institution must be provided for the sizeable population of retarded persons who are capable of partial independence. Unless this is done, the state school will, sooner or later, become the ultimate home of many persons who are capable of enjoying the freer, more independent, more dignified and more humane life in the community. With the assistance of federal funds, these facilities could be operated at less cost for care than hospitalization. The halfway house concept can be used to provide trial periods prior to release or transfer to less restricted facilities. It should stress the concept of deinstitutionalization and be adequately staffed to help bridge the gap between many years of crowding and regimentation, of almost complete lack of opportunity for decision making or responsibility for personal choices. Failure to provide such a "decompression chamber" experience may lead to the erroneous conclusion that many persons cannot adjust in the community because they precipitate various crises or fear to participate in any new activity.

The Department of Mental Health should investigate the development of community group homes for adult retardates who need minimal supervision and care, who are employed, or who participate, in training programs. Contractual operating arrangements with local organizations should be considered if flexible staffing and programming is to be provided under the supervision and standards to be developed by the Department of Mental Health. There are many retarded adults who cannot gainfully work, even in a sheltered community workshop. However, they are in good physical health and do not require hospital care. The provision of adult colonies could be accomplished at a lower capital investment, less staffing cost, and with a maximum of self help, and independence for the retarded person. In a humane and social sense, their existence would be far superior than under the almost unavoidable regimentation of a large institution.

STANDARDS AND COMMUNITY RESEARCH

Lack of standards, poor organization, and coordination of services inconsistent licensing requirements lead to constant confusion, duplication of effort, and ad hoc decision making. Although the initial standard setting and compilation would be somewhat onerous, a framework for evaluation and constant updating should be established and clear guidelines should be available. A manual of standards for facilities, services, personnel and licensing arrangements for retardation programs should be published and kept current by the proposed Office of Retardation.

A major evaluation tool for developing community programs is the establishment of statistical indicators of client and service patterns. Most of the current statistics on the retarded relate to those residing in institutions. Information is necessary on changes in clients over time, so called longitudinal studies of developmental changes. Other key research areas are studies regarding the extent to which certain groups of the retarded tend to "disappear" into the population as well as changes in community attitudes toward the retarded as new programs are introduced.

REORGANIZING RESIDENTIAL PROGRAMS

RECOMMENDATIONS

IMMEDIATE PERSONNEL NEEDS

26. All personnel additions to the four state schools for the retarded recommended by the Report of the Special Commission on Retarded Children, No. 3400, December 1965 should be provided immediately. It would be impossible to implement the plan contained herein without the availability of a minimum personnel base, especially in the direct care, clerical and maintenance categories.

BUILDING ADDITIONS AT EXISTING STATE SCHOOLS

27. Any new building additions at the existing state schools for the retarded should be for replacement purposes only and should be guided by this report's emphasis on decentralized, small unit living arrangements.

The Department of Mental Health should immediately undertake a study of the adequacy of existing buildings, as well as the building needs of the existing schools.

FUTURE RESIDENTIAL FACILITIES — UPPER LIMIT OF 500

28. All future residential facilities should house no more than 500 who reside on a 24 hour basis. Where appropriate for specialized purposes, installations should be developed with an even smaller maximum capacity.

REORGANIZATION OF STATE RESIDENTIAL SCHOOLS

29. State residential schools for the retarded should be reorganized to stress individualized developmental and social growth programs for residents. Reflecting this change, state schools should be renamed and called Regional Residential Centers for the Retarded.

FUNCTIONAL UNITS ACCORDING TO MEDICAL AND NON-MEDICAL UNITS

30. Semiautonomous functional units should be established and organized according to age groups and extent and nature of capabilities and handicaps.

Two primarily medical units should be established, a Hospital Unit and an Infirmary Unit. Three primarily nonmedical units should be established, a Children's Unit, an Adolescent Unit and an Adult Unit.

ASSISTANT SUPERINTENDENT OF SOCIAL DEVELOPMENT, EDUCATION AND TRAINING

31. A new position of Assistant Superintendent for Social Development, Education and Training should be established to supervise all nonmedical functional units and to provide consultation for social development programs to hospital and infirmary units.

ASSISTANT SUPERINTENDENT OF MEDICAL SERVICES

32. An Assistant Superintendent of Medical Services should be established to supervise hospital and infirmary units and to provide necessary medical services to all other functional units.

ASSISTANT SUPERINTENDENT OF MANAGEMENT

33. An Assistant Superintendent of Management should be established to actively assist social development and medical staff in providing optimal community life for residents. This should be accomplished through and in addition to fiscal responsibilities and supervision of dietary, engineering maintenance, laundry and farm services.

DIRECTOR OF FUNCTIONAL UNITS

34. New positions of Directors of Functional Units should be established to supervise and coordinate an integrated program for developmental needs of residents in the functional units.

BUILDING SUPERVISORS

35. Qualified and upgraded Building Supervisors should develop homelike social programs under the direction and supervision of unit directors to permit and encourage the development of small friendship groups within which residents can identify with a small, stable family like group.

DIRECT CARE PERSONNEL

36. Training and upgrading of existing direct care personnel should be instituted and extended where already begun to implement an individualized and small group approach to residents.

IMPLEMENTATION TEAM

37. An implementation team should be formed in each Regional Center for the Retarded consisting of the superintendents and other key medical and program staff and department heads to arrange the steps of transition from the present institutional structure to the functional unit structure. Transitional phases for each residential center will vary in duration, depending upon the multiplicity of factors involved in any change of this dimension.

RESEARCH

38. Continuing research, basic and applied, as well as preventive and remediative, should be carried on in each Regional Center and in each of its functional units. A Director of Research position should be established to promote and implement these functions.

CENTRAL OFFICE CONSULTANTS

39. Complementary positions for consultants for the recommended functional units — medical services, children's services, adolescent services and adult services — should be established in the central office of the Division of Mental Retardation to assist each Regional Center in developing and implementing its functional unit plan.

AREA FUNCTIONS OF THE REGIONAL CENTERS

40. Each Regional Center for the Retarded should provide for the area in which it is located a wide variety of community services, such as consultation to local agencies and services on problems of home care, education, training, placement. It should provide a day program consisting of vocational training and day care for the retarded of the area who live at home.

REGIONAL FUNCTIONS OF CENTERS

41. Areas in a given region should look to the Regional Residential Center to provide specialized diagnostic and evaluative services, short and long term residential care and other forms of consultation and services which an area may not be able to provide.

RELATIVE'S FINANCIAL RESPONSIBILITY

42. Fee payments by parents or relatives should cease when the child in residence at Regional Centers reaches the age of 21.

43. Relative's financial responsibility for education costs for residents of regional centers should be eliminated.

A NEW APPROACH

There are benefits to viewing the goals and task of residential institutions, from the perspective of residents, the administration of the institution, and the outside community. Institutions serving the retarded have shifted from the protection of the retarded individual and of society as the primary and all encompassing goal to a focus upon broadening opportunities for growth and independent functioning.

Residential schools must provide:

- An emphasis upon social development.
- An individual and small group approach.
- Meaningful links to the community.

A variety of resources will be necessary to implement these goals. These resources include facilities, changed spatial arrangements, additional and changed distribution of personnel, and additional and changed emphases in programs. These changes, particularly changes in personnel and programs, will ultimately make a major difference in the success or failure of an attempt to strengthen the social development emphasis.

Many deficiencies of residential care for the Commonwealth's retarded have already been identified to the public in the reports of the Special Commission on Retarded Children, #3601, May 1964, and #3400, December 1965. An immediate upgrading and commensurate increase in salaries should be instituted for all direct care personnel.

Gross inadequacies in residential buildings, the serious degrees of overcrowdings, the long waiting list for residential care, and the gross shortages of personnel need not be reiterated. This does not mean that these essential needs to the retarded of the Commonwealth are not being stressed. On the contrary, this Project adds further support to the recommended programs to alleviate these conditions.

The Department of Mental Health has under development an organized plan to work towards the remedy of many of these deficiencies, including the construction of new infirmaries at Fernald and Dever State Schools, the construction of new residential facilities at Templeton, and replacement of the farm colony buildings at Belchertown with modern buildings. At the present time, the first phase of construction of the fifth regional center, Hathorne State School at Danvers, is nearing completion.

A program for 200 retardates will be provided at Rutland Heights, along a model similar to the North Reading Rehabilitation Center. A combined training center for special class teachers and a treatment center for the retarded is developing at Fitchburg.

Requests are being placed before the Great and General Court for four residential centers for the retarded; three in our greatest centers of population, Boston, Worcester and Springfield. Each center will provide services for up to 500 retardates in residence as well as vocational training, day care, community consultation, and other supporting services to these densely populated areas. A residential center is being requested at Pittsfield to serve the western part of the state. Plans call for this center to serve both the retarded and the emotionally disturbed, thereby becoming a pilot demonstration in providing a comprehensive service to children. In all, residential provision for more than 2,800 retarded persons will be provided during the next decade if current plans are implemented.

Each necessary step should be made to rehabilitate and modernize construction to introduce more congenial, smaller and more livable sleeping and living accommodations necessary for the successful implementation of recommendations included in this report. All new construction should incorporate this philosophy of decentralized, small unit living arrangements.

Vigorous emphasis must be given to the fact that the recommendations for action proposed in this report cannot even begin moving toward implementation without the inclusion of the minimum personnel requirements recommended by the Special Commission on Retarded Children. Special consideration must be given to the additions of direct care, clerical, and maintenance staff. No program can move beyond mere survival and maintenance of its status quo without adequate provision for primary supportive personnel.

This report describes a program which is both manageable and attainable. At the same time, there is no pretense that the recommendations are exhaustive. Taken together, the recommendations represent a framework for change based upon the central consideration that the existing institutional

establishment is impoverished. It has shortcomings which it recognizes. It has lacks which all will agree should be eliminated.

There are essential lags in the development of the structure and organization of the institution, its relation to the central department, and its relation to the community, parents, professionals, and other services which require remedy.

Any one of these developments cannot be considered in isolation, each will reinforce each other. The over-all aim is to:

- Eliminate gross deficiencies in traditional services.
- Accept the newer developments in professional and scientific knowledge.
- Alter an organization so that it can accept, integrate, coordinate and utilize these changes.

A SOCIAL DEVELOPMENT APPROACH

Existing structures of state residential schools make social and activity programs a secondary consideration only taking place after caring for the essentials of security, custody, and health. However, wherever social activity programs have been introduced, they are enthusiastically received by parents, the matrons of the buildings, and other personnel.

The essential problem of the state residential school for the retarded is that care is provided on a nonindividualized basis. An overlarge mass production system provides medical care, custody and security, but not small group and individual relations essential for stimulating and reinforcing social growth potential. By increasing staff in large numbers some alleviation may occur. But, pertinent social science findings tell us that institutions cannot provide individual care unless they are broken up into smaller units.

Resources for the direction and supervision of social and recreational programs appear woefully inadequate. There is no one person on an administrative level who has the specific responsibility for seeing that the residents of the state schools have adequate social programs. Therefore, it is not difficult to understand why social and activity elements are not a more essential ingredient of the program for the retarded.

THE CULTURE OF THE STATE RESIDENTIAL SCHOOL

Prior to modern specialization, long term care institutions were oriented toward developing a wholesome social life for all their patients. This was not difficult in the small institutions of the period. As institutions became larger and specialization increased, whatever social life occurred was standardized and mass produced. Professional groups differed in their viewpoints as to the type of social life that was appropriate. Not until the present period have many of the inconsistencies and peculiarities of the social life of patients again become apparent.

From many different levels of observation it appears that state schools exhibit a firm bias in the direction of formal schooling, strict discipline of behavior, strong control and a concern with protection, both of the individual and of the outside community from the retarded person. These rigid guidelines can impede social development and maturation. The normal spontaneity of childhood and adolescence can be misinterpreted as bad behavior. Historically, one of the principal goals for the retarded was to train them in "good" behavior so that they would not be a menace to society. It seems as if there is an unwritten motto, "If you can't be bright, at least you can be good."

State schools have been described as "static," "custodial," and "inactive." The institution is a slow moving community changing little over the years. Much of this is realistically inherent in the structure and function of the state school. A child admitted at six may be educated or trained and possibly leave as a young adult. If the problem is of a more difficult nature, he is there for life. Nothing approaches the tempo of the few weeks or months of intensive treatment applicable to most of the mentally ill. No concept in the institution places significant value on short term emergency or temporary care or treatment.

In Erving Goffman's book, *Asylums*, inactivity is attributed to the institution's complete separateness from the outside community and to its self sufficiency. The more the outside community is simulated within the institution, the more the activity and the higher the probability that the institution will approach the activity of the outside community.

CLARIFYING JURISDICTIONAL DILEMMAS

A large variety of buildings exist for use by residents. These buildings fall into the following types:

- New nursery buildings
- Older nursery cottages
- Hospitals
- Infirmaries
- Dormitory cottages
- Farm buildings

Present living arrangements have a number of serious drawbacks. Schools have not developed uniform classification systems for assigning residents to buildings. Different assignment practices are especially evident in the dormitory cottages for older children, adolescents, and adults. Wide age spans and a considerable range of mental, social, behavioral, and physical characteristics and abilities are evident in some resident buildings. Pressures of overcrowding of the state schools make it understandably difficult to effect homogeneous living arrangements. Yet, granting this limitation, progress can be made toward a more functional classification system which would permit a comprehensive and integrated approach to the total development and medical needs of residents.

It would be very difficult to develop such a system under the present structure. The resident in today's institution may be the object of a number of systems of care. His medical care is entrusted to the medical service; his daily physical welfare becomes the responsibility of the nursing service and attendant staff; his education is the concern of the school department; other special needs may be considered by other specialties. Each service or specialty tends to view the resident from a specialized vantage point. To the physician he is a medical problem; to the nurse, a personal care problem; to the educator, a learning problem. The list of special problems extends to the number of included specialties.

No single discipline of specially designated official except for the superintendent concentrates upon the total developmental and medical needs of the residents. The superintendent cannot be expected to perform the complex task of integrating the program objectives of a variety of services and disciplines for each resident. Nor can the integration be achieved through joint conferences among the disciplines since each specialist understandably tends to consider his contribution pivotal, if not preeminent.

Historically, doctors, nurses and teachers have dominated the institutions. Their efforts have provided the conerstone of care furnished to the institutionalized retardate.

New staff cannot be easily introduced into institutions that have operated for decades with a simple, basic roster of personnel. In many instances, overt or covert resistance has marked the introduction of newer programs and of newer personnel.

Resistance to new programs may reflect a careful and well founded skepticism about the validity and usefulness of newer programs; or may result from the belief that newer programs may diminish the resources of the state and of the institution. Medical, nursing and teacher groups already in the institutions, may offer resistance or be disinterested because they believe that each institution is predominantly either a hospital or a school and should be administered accordingly.

Three departments dominate direct care services in the existing organization of the state residential schools — the medical service, the nursing service and the school department. The state legislature has increased its allocations for positions for many of the newer social and behavioral disciplines. Emphasis upon these new positions reflects a recognition that social and behavioral approaches should be stressed as important components in a well rounded care, training and treatment plan for residents. Yet, the newer specialties arrived in the institutions later than the established disciplines. A basic framework for providing services had been established. The roles of social service, psychological, recreational and newer occupational and vocational approaches were, in a sense, grafted onto the existing structure of services. One of the issues which has remained essentially unclarified is the extent to which the newer personnel have direct care functions rather than indirect consultative or advisory functions.

The reorganization plan suggested in this report attempts to clarify some of the jurisdictional dilemmas posed by the introduction of the new disciplines.

THE NEW FOCUS

Substantial reviews of the needs of the retardates and a systematic study of the structure and function of the institutions will still be required on a continuing basis. However, scientific and professional knowledge permit these significant conclusions:

- Traditional concepts of institutions, hospitals, and schools should be changed to stress residents' developmental and growth potentials.
- Changes in organization of personnel, administrative arrangements, spatial requirements, and classification of residents must reflect an individual and small group approach.
- The increase in the proportion of severely retarded residents in the institutions requires an intensified research and study effort. Programs should be organized that are socially and developmentally, rather than custodially oriented.
- Currently dominant professional groups — physicians, teachers and nurses — must be expected to share the responsibility for determining institutional management and programming with the newer groups coming into the institutions.

Given the focus of finding ways to provide a stimulating and varied social experience for residents, a basic question must be: How can the Commonwealth's four large institutions decentralize to achieve these ends?

THE FUNCTIONAL UNIT PLAN

At present, each residential school for the retarded, except Hathorne, accommodates between 1,200 and 2,200 residents. Modern practices throughout this nation and others point to the benefit derived from smaller, more manageable living arrangements. Nevertheless, overcrowding and pressures for admissions to residential centers make it impractical and grossly uneconomical to dismantle the multimillion dollar investments represented by the existing institutions.

New, smaller residential centers will open in Massachusetts in the near future — others are in the planning stage.

Present accommodations, together with those planned, will barely meet projected residential needs in the next decade. In view of the necessity to retain our present overlarge residential facilities, the pressing question arises: How can large complex residential centers be converted into smaller semiautonomous communities to provide the inherent benefits of more individualized approaches to residents?

The existing diffuse, disfunctional organization forces personnel to work with overly large numbers of residents. Staff members have little time to really get to know residents and to learn how to individualize care, treatment and training for them. A functional unit plan would reduce the number of residents for whom direct patient care personnel and other professional personnel are responsible. An essential objective of the functional unit plan would aim to develop semiautonomous communities within large multifaceted institutions where specialized and appropriate programs could be provided, varied for different age groups and the extent of disabilities.

A first step towards the goal would divide the institution by residents with predominantly medical needs and residents with predominantly nonmedical needs. Those in the former category who are chronically ill or acutely ill would be patients in hospital buildings.

The buildings, the patients and the staff serving them would comprise the medical — hospital and infirmary — functional units of the institution. Medical and personal care services would be the major services given in these units, but social and other developmental elements should also be introduced and maintained.

As will be described in detail later, the Assistant Superintendent for Medical Services will supervise the medical unit with the assistance of hospital and infirmary directors (with the possible addition of a director of clinical services). The program, the personnel, the buildings and the classification for resident inclusion are relatively clear cut for the medical units; not so for the proposed nonmedical units.

The nurseries, dormitories and the farm buildings comprise the living quarters for residents not requiring the intensive bed care of the medical units. Recommended steps for achieving an integrated developmental program for these residents include:

- Grouping resident buildings into units which will house infants and children, adolescents, and adults.
- Hiring unit directors who would study the program and personnel requirements for each unit, assemble a staff from existing personnel blocks, and assess the need to add additional positions not now available to the institution.
- Subdividing living arrangements according to chronological age groupings and developmental potential.
- Giving each unit line responsibility for preparing an integrated development program for all residents within the jurisdiction of the unit.

- Placing all nonmedical units under the supervision of an Assistant Superintendent for Social Development, Education, and Training.
- Limiting medical supervision to the provision of necessary medical service under the direction of the Assistant Superintendent of Medical Services.

By providing homogeneous groupings of residents for both living and program purposes, the plan takes into account the possibilities for programming both in living quarters and outside these quarters for groupings of residents with similar age and potential. By appointing a unit director with general, rather than specialized, responsibilities for a unit composed of residents within specified age ranges, the plan delegates to one person the responsibility and the coordinating authority for the total developmental needs of residents within the unit. By allocating personnel trained in a variety of specialties as "line" workers within the unit, the plan attempts to minimize the fragmentation which occurs when a variety of specialties claims jurisdiction for specialized program objectives for each resident. By placing all nonmedical units under the supervision of an Assistant Superintendent for Social Development, Education and Training, the plan places emphasis upon social, behavioral, educational, and vocational objectives. By limiting medical direction to actual physical care requirements, the plan makes provision for requisite medical treatment and limits the possibilities for medical dominance in areas which are primarily nonmedical.

A description of the organization of proposed functional units follows:

Functional Unit	*Orientation of Unit Director and other Key Personnel*
Hospital (all ages)	Medical and nursing direction utilizing the modern skills of both.
Infirmary (all ages)	Medical and nursing direction utilizing the modern skills of both.
Children (ages 0 – 12)	Child development, education, pediatric and child psychiatric direction.
Adolescent (ages 13 – 21)	Education, vocational training and social development direction.
Adult (ages 22 and over)	Vocationally oriented, "town manager" type.

Rather than preserving its present narrow professional leadership or changing it to some other narrow professional leadership, the institution would be organized into functional components, each with leadership appropriate to the type of service to be provided for residents.

Experience with the organization of constructive programs within functional units will reveal to what extent each one of these units will depend upon each other unit and upon combined facilities, academic facilities, institutions or industries.

However, the establishment of functional units alone will not be sufficient to bring about the necessary changes unless implementation proceeds along the following lines:

- Each unit should select its own personnel consistent with the unit program objectives.
- Each unit should instruct its own personnel.
- Each unit should supervise its own personnel.
- Each unit should participate in evaluative research which assesses its program and effectiveness.

ADMINISTRATIVE REORGANIZATION

To accommodate the functional unit plan and allow for an orientation that concentrates upon social and activity programs, an administrative reorganization of each institution will be required. The new organization is shown in Figure 1.

CHANGED ROLE OF STRATEGIC PERSONNEL

The Superintendent

Traditionally the superintendent has been in the complex and peculiar position of being the key person directing an institution with a wide variety of problems and needs. He has never been provided either the personnel to develop the necessary organization and administration, or with sufficient personnel of high professional caliber trained in growth and development.

With the advent of large multifunction regional centers, the superintendent will need expertise in both the medical and the social development areas.

The superintendent should be in a position to differentiate between medical and nonmedical program goals and to promote and control these directions as appropriate.

This function will require sensitive analysis especially since supervision of severely and multiple handicapped retardates will continue to take on increased importance if current demands for space continues for these groups.

The Assistant Superintendent for Social Development, Education, and Training

The person occupying this position should be drawn from the fields of psychiatry, psychology, social work, education or rehabilitation. He should have had previous administrative and therapeutic responsibilities for clients covering a broad range of age groups in residential settings. His duties should consist, in part, of administrative and program direction of the nonmedical children's, adolescent and adult units. He will supervise functional unit directors in developing program goals and methods for working toward individualized treatment, training, educational and vocational goals for residents of these units. He will consult with medical personnel for assessing the needs for social growth programs in the hospital and infirmary units. He presents his analysis of need to the Assistant Superintendent of Medical Services and the Superintendent for working out personnel and material requirements for social growth programs in the medical units.

The Assistant Superintendent for Medical Services

This key staff person should be a board certified physician with specialized training in an appropriate field, different, when possible, from that of the Superintendent. His duties will entail the medical care and management of all residents.

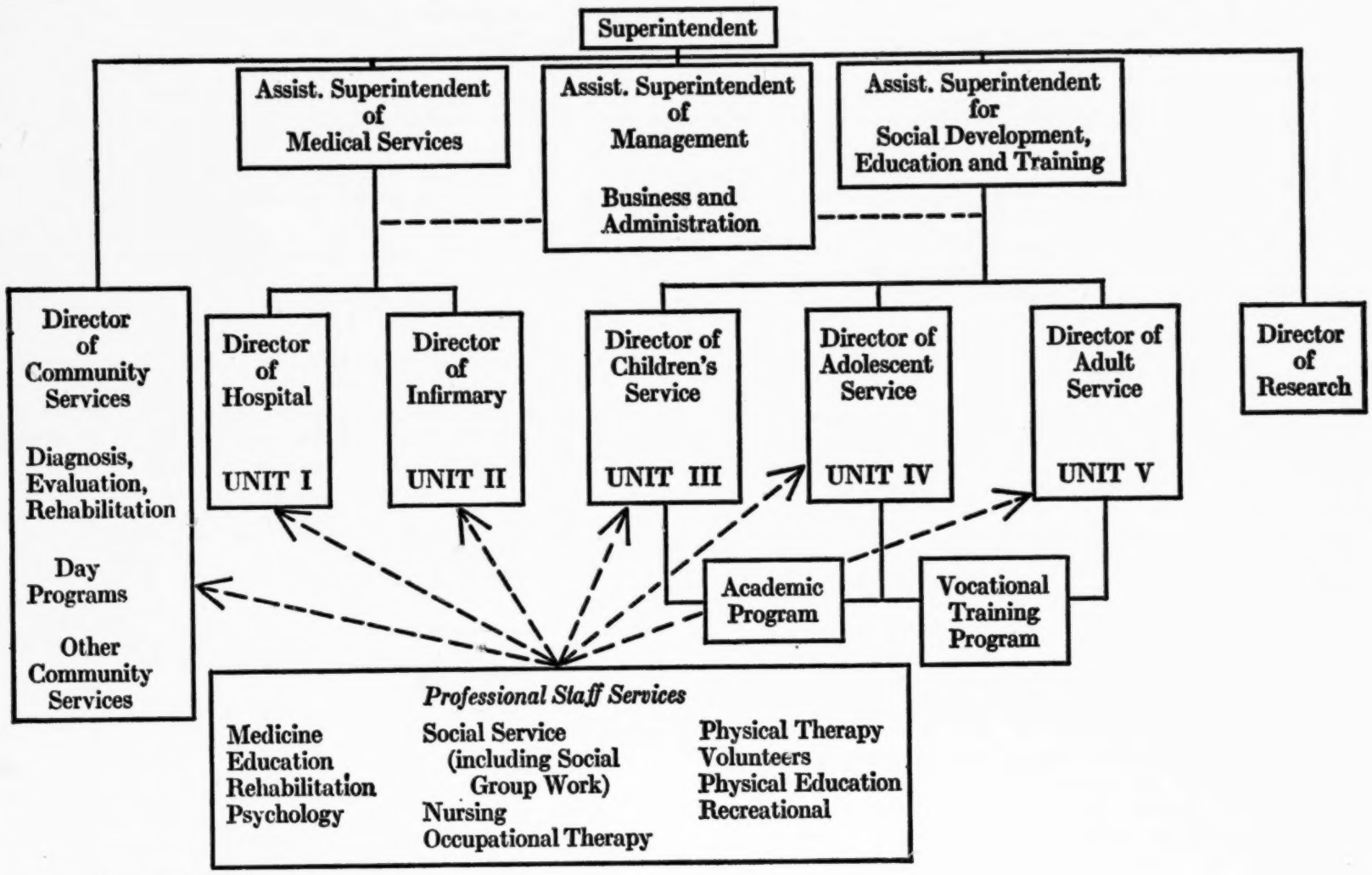
He should work in close collaboration with social development personnel. He will be responsible for direct supervision of hospital and infirmary units. Also, under the superintendent and in collaboration with the Assistant Superintendent for Social Development, Education and Training, supervise the provision of all medical treatment in the children's, adolescent, and adult units.

The Assistant Superintendent for Management

This position requires a person with the skills of modern management and administration, particularly one who has had experience in applying these skills to institutions. His preferred credentials should include a master's degree in hospital administration or hotel management. The responsibility would include everything that is involved in providing a

FIGURE 1

MULTI-FUNCTION REGIONAL CENTER FOR THE RETARDED



pleasing living circumstance — the aesthetics of walls, furniture, and decorations, and providing the opportunities for indoor, outdoor, and off the grounds recreational life. He organizes the dietary service in an aesthetic and pleasing manner. Service agencies of the institution, such as the laundry, farm, and engineering maintenance should be administered so that they focus upon providing optimal community life. This requires full cooperation with medical, social development, educational and training personnel, who will be utilizing these facilities for training, education and other program purposes.

To a great extent, the existing position of steward could provide the framework for this changeover. By selecting and developing stewards with training in the area of community and hotel management, suitable individuals to develop this environment could be employed. Direct team work and close collaboration between the new community manager and the social development and medical personnel, will be essential.

FUNCTIONAL UNIT DIRECTORS

This scheme requires the hiring of unit directors who would be appointed on the basis of their training, experience and orientation to the age and level of disability of the unit they will head.

The professional label of the unit head is not as important as his basic orientation and general experience. The professional skill that is most appropriate and pertinent to the type of unit would be the one that usually would be chosen. (The hospital and infirmary units would be headed by physicians.)

Directors of the functional units will be directly responsible to the Assistant Superintendents for Social Development, Education and Training, or Medical Services. In turn, the Director will plan for the selection of professional and subprofessional personnel from all staff categories employed at the institution. He will set out developmental objectives for each individual in the unit. He will cooperate with personnel from professional offices who will provide staff consultation to persons in their professional areas assigned to the unit. He will be expected to develop appropriate inservice training so as to enhance the contributions that the staff members in his unit will make to the social and recreational life and development of residents.

Each unit will be expected therefore to follow a somewhat different course, depending upon the characteristics of residents and the orientations of the staff selected to help.

THE BUILDING SUPERVISOR

The building supervisor is the most crucial person in the line system of clinical responsibility. It is he who is the direct link between the resident and the administrative and professional hierarchy. The building supervisor is the person directly responsible for the implementation and coordination of the resident care programs and for the on-the-spot super-

vision and training of attendants or child care personnel. Surveys and direct experience have shown repeatedly that information about the daily life of the resident and conditions on the living unit is most completely conveyed by the supervisor (or held back or distorted when the supervisor is under pressure, is angry or feels deprived of help from below or support from above).

A prerequisite for implementation of a care and growth plan is adequate numbers of personnel to work directly with the residents. This, of course, in turn influences the effectiveness of the supervisor. There must be enough personnel working with the residents to enable the supervisor to delegate various tasks, such as personal hygiene, clothing care, meal time training, and recreation. It is necessary that the supervisor be freed by this process of delegation to plan, to coordinate, and to give direction.

In a living situation where the orientation is toward overseeing rather than interacting with residents, staff people sometimes complain that they do not have enough time to do things with patients or residents. Conversely, it has been demonstrated (e.g. Children's Unit Metropolitan State Hospital) that where interpersonal skills are stressed and some inservice teaching provided, personnel do find time to interact on a more positive basis with residents, to implement social and recreational programs, to involve resident initiative and to find sufficient time even on the least trained level to do planning for activities.

Under this plan, emphasis is given to the potentialities for training and self-care on the part of residents themselves. Obviously, this would vary in terms of the basic capabilities of various groups of residents.

The building supervisor must preserve the link between the resident and all other parts of the institution. This means being actively involved in many of the different programs which the resident engages in daily. In practical terms, this means joining in with the residents even to the point of sharing a meal with them, participating with them occasionally in the games or songs that they enjoy, going with them when they, as a group, go to school or on a trip into the community. There are several specific reasons why this function is crucially necessary. In the first place, for the building supervisor to be an accurate reflector of resident attitudes, needs and capacities, he or she must be familiar on a direct practicing level with their daily lives. This enables the building supervisor also to view the job and the life of the patient as it is seen by the attendant or child care worker. Secondly, it forms an effective working parent-child bond between building supervisor and resident. Third, for persons who are relatively untrained or unsophisticated in methods of resident care or who have developed passive overseeing habits in the course of their experience, it is necessary that the high status building supervisor lead the way by example or precept even before an attempt is made to teach on the conceptual level. In addition to this there is encouragement, approval and a breaking down of the barrier between boss and employee. Experience indicates that it is probably only in this way that the barrier between employee and resident is likewise broken down.

Building supervisors should help to coordinate programs both inside the living unit and outside it. They serve as a link between the building staff and professional and administrative staffs for the implementation of all programs. Included with this function are specific activities such as conferences, with building staff and with professional and administrative staffs on both a separate and joint basis, some time for supervision from their administrative superior, and opportunities for participating in seminars to increase general knowledge and skills.

Contact with parents should be on a regular basis. Here again, the building supervisor is the indispensable parent surrogate who should maintain communication even to the point of an outreach program to involve families who have not previously kept in contact with the daily lives of their institutionalized relatives.

This position should not be restricted to a person trained in nursing. In buildings where physical care is the predominant need, a nurse-trained supervisor would probably be most desirable. However, appointment should be based in general on the skill, personal qualities and the philosophical outlook of the individual. Many private child institutions think of the supervisor as a senior child care specialist and consider persons of varying background for the position.

It will be necessary to provide regular, ongoing inservice training for building supervisors, since at present there is no profession or school that trains people specifically for such a position. Indeed, this may spell the difference between success or failure for the development of effective persons and programs for resident care and growth.

ATTENDANTS

Review of the roles of direct care personnel in dormitories or building residences clearly shows a vast confusion and often contradictory set of responsibilities. Other personnel have simply not been available to assume these many responsibilities. Direct care personnel have suffered perhaps more than any other group within the institution from the low level of resources assigned to the retarded.

Attendants are administratively assigned to the nursing service and act within the mandate of that program and its responsibilities. The stress on nursing care has emphasized the physical care features of institutional programming, such as feeding, washing, dressing, protection against self harm and harm to others. On the basis of the manner in which institutions have developed and have been supported, this emphasis is understandable. In large part, it results from and is inextricably connected with the shortage of personnel. Maintenance of life and avoidance of injury or death are inherently all this type of care can provide.

It is of paramount importance that:

- Roles of direct care personnel be redefined.
- Additional personnel be hired.
- Large and extensive inservice training programs be expanded where they now exist and introduced where they do not.
- The roles of attendants permit a concentration on child care and social development experiences.
- The recommended establishment of functional living units based in significant part on redefined, strengthened roles for attendants.
- Support be provided through appropriate education and training that will permit attendants to provide a wide range of social learning opportunities and experience for the adult retarded.

Direct care personnel are the most critical group of personnel in the institutions, on the basis of the amount and type of direct contact with residents. No other group, either professional or nonprofessional, does as much for, and with the residents.

All such personnel should be trained in one functional area: medical (hospital and infirmary), infant and child, youth, or adult. The role should be more specialized to reflect the programs for the type of person for whom he has responsibilities. Each of these positions should give to the

worker the title appropriate to his work, for example, "child care worker" or "youth worker."

While roles are vital, appreciation of their significance, unfortunately, has been limited. Attendants, for example, are sometimes viewed as a source of resistance to innovation and improvement in patient programs. Salary levels are low. Opportunities for the upgrading of personnel within the attendant category are restricted.

Inservice education programs for attendants have demonstrated their effectiveness and should be extended to include additional training in the areas of social development. Much of this inservice training is fully applicable to *all* personnel who have direct contact with residents — farmers, launderers, food service personnel.

Over the years, a number of efforts have been made in this state and throughout the country to introduce job ladders for personnel which would provide for advancement.

The position of direct patient care personnel requires a degree of intelligence, skill, human sensitivity and responsibility that must be recompensed accordingly. Compensation must be both in terms of financial remuneration and in terms of status and respect within the institutional community and the community outside. This may be accomplished by orientation and training at the beginning of the experience and by repeated periods of higher learning and specialized training and step-up job increments appropriate to training responsibility.

A variety of lateral and oblique upward movements should be possible for those with specialized interest and ability in such areas as recreation, industrial and vocational training.

Consideration must not be limited to the career worker. Many institutions have given insufficient attention to the young person who, although he does not care to become an attendant as a lifetime work, yet sees it as a valuable internship in human relations. Most of these are college students who will be going on to the professions of social work, psychology and nursing. Not only do they make a valuable contribution to the institution, but they are receiving an internship which leads them into professional levels in the helping professions.

The diversity of backgrounds represented by the high school and college students, as well as the career attendant produces increased interests, transfer of ideas, and excitement in their vocational endeavor.

The federal government has taken the first step in stimulating young people in this direction by the enactment of legislation which provides for the training of aspirants to the various professions dealing with mental retardation at the high school and college level, in programs conducted in facilities for retarded persons. A number of agencies and at least one professional association in Massachusetts have made application for the training program. A continuation of these efforts is to be strongly encouraged.

OFFICES OF PROFESSIONAL STAFF SERVICES

Under the functional unit plan, professional and subprofessional interdisciplinary teams will work in concert to provide a rich direct care experience to residents. Knowledge acquired about interdisciplinary efforts in a variety of settings points to the need for consultation for the stimulation of ideas and professional support from sources outside the team or unit.

Consultation should take the form of professional support and guidance from experts familiar with the unique problems of the institution who should therefore be part of the institution staff.

One or two consultants from each discipline according to the plan advocated by this report, would be "on call" to assist the units. They should form a pool of professional resources emanating from office of professional staff services (See Figure 1).

The reorganization plan provides for professional offices in the staff areas of psychology, rehabilitation, education, medicine, social service (including social group work), nursing, occupational therapy, physical therapy, physical education, volunteers, and recreation. Heads of these staff areas will provide the professional stimulation, leadership and support to the people of their professional groups, as well as others working in the various units.

The provision of consultative services will not be administrative, but will rather be a matter of professional stimulation and concern.

ELIMINATION OF RELATIVES' FINANCIAL RESPONSIBILITY FOR EDUCATION

One of the most glaring inequities of fees charged for institutional care and support of the retarded is the inclusion of the cost for education as part of the total cost of care. This is double taxation. Parents of institutionalized retardates must still pay taxes to support local public schools, and at the same time pay a fee to obtain the benefits of education in a state residential institution. Education in a state institution for the retarded is a substitute for public school education and as such should not have a price tag attached. The retarded in state residential institutions should not be exempted from the well established tradition of free public education for all.

ELIMINATION OF RELATIVES' FINANCIAL RESPONSIBILITY FOR ADULT RESIDENTS

The Planning Board strongly endorses eliminating financial responsibility of parents and relatives of institutionalized retardates 21 years of age or over. Parents and relatives should not be expected to bear the financial brunt of care and treatment for dependent adults who, had they not been retarded and in need of institutionalization, would be self supporting or supported by other public benefit programs.

Under Chapter 123, Section 96, of the General Laws, the Department of Mental Health is responsible for determining fees for support of residents in the state schools and collecting payments from the relatives responsible. In fiscal 1966 the Division of Settlement and Support collected about one and one-half million dollars for support of residents in state schools. This amount represents a small percentage of total cost of care. In many cases support payments are reduced from the maximum daily rate of $7.70 or waived completely.

Support payments by parents or relatives should cease when a child in residence at a state school reaches the age of 21. Although the amount collected is only a small percentage of the state school budget, it may represent a considerable financial drain on individual family resources, expecially if institutionalization is of long duration.

Many states restrict relatives' financial liability for retarded in state's care. In Minnesota, Wisconsin and Hawaii, for example, liability of parents is restricted to children under the age of 21. In Iowa parents' liability decreases as the age of the resident increases. Connecticut limits liability at the age of 21 or after 16 years of residency, whichever occurs later, and the state of Washington levies no charge whatsoever for care of the retarded[1].

[1]For a recent compilation of state programs and policies, see Report of the Legislative Research Bureau on Reimbursement for the Care of Mental Patients, House No. 3380, Feb. 1962.

Massachusetts should join those states which limit financial responsibility to parents of residents under 21. House Bill 2843 (1966), recently considered by the House of Representatives and set aside for further study, would accomplish this purpose and should be passed as soon as possible.

RESEARCH

A position of Director of Research should be established at each Regional Center. Necessary staff should be provided to support a research program which will contribute to general knowledge about retardation, and to provide findings and information which will contribute to the welfare of the residential population.

Primary research functions should be concerned with exploring all aspects of the problem of retardation, accumulating and disseminating data of ultimate relevance in the identification and prevention of this problem, and in its clinical and social care, direction and remediation. Secondary functions should be concerned with providing opportunities for highly specialized professional personnel to involve themselves in a creative, stimulating and productive research atmosphere which will act as a stimulus to the recruitment of professional persons into the field.

The research enterprise of the residential facility should be involved in the continuing operation of the Center in the following special ways:

- Consultation to all functional units regarding research design and use of research findings.
- Supervision of research necessary in each functional unit to evaluate remediative procedures (behavioral and medical), to analyze the behavioral capabilities and deficiencies in the residents of the units and to advise in the design and application of specialized procedures for behavior modification.
- Direct involvement in the service training to help create an experimental orientation among all direct care and supervisory personnel as well as reliable methods of continuing data gathering to reflect each resident's behavioral reactions to specified care and training procedures.
- Provision of pre- and post-doctoral research training in social and behavioral sciences.
- Helping to develop state, federal and private grant support for research and research training programs essential to the continuing improvement of rehabilitative and prevention programs.

EVOLUTION TO REGIONAL CENTERS

The idea of the state residential school as a multifunction Regional Center means opening up interaction and communication between residents of the institution and the outside. It means as well that the institution should be seen as the Regional Center for the service to be provided for the retarded in the entire region within which the center is located. In addition to a wide range of intensive diagnostic and evaluation services to be provided by evaluation-rehabilitation clinics, the Regional Center should develop training, day programs, and other types of short term and long term, partial residential care, staff training and other types of supportive services in cooperation with other agencies and care givers within the region.

Additionally, the regional residential center may serve as a major area retardation facility for the local service area in which it is located. Each Regional Residential Center for the retarded should provide for the area in which it is located a wide variety of community services, such as consultation to local agencies, services on problems of home care, education, training, and placement. It should provide a day program consisting of vocational training and day care for the retarded of the area who live at home. It should offer a halfway house facility and program for residents in transition between the Center and the community.

Merely designating service functions will not assure that the residential center or community of residents and staff will benefit from the stimulation from its outside environment. Careful groundwork must first be laid inside the institution. The proposed reorganization of the center with its emphasis upon social development programs and accompanying personnel allocation will provide an important first step. Another step will be to encourage the institution to extend residents' freedom of movement on and off grounds. The quality of parent-institution relationship and service to families will prove crucial factors. Another will be the manner in which volunteer programs continue to develop.

There must be developed a very careful balance in community relations which insures that energies are not drained away from the institution's needs thereby working to the detriment of the institution and its residents. Yet, measures should be continued which discourage stagnation and dissatisfaction which comes from professional and social isolation.

Efforts which select out and relieve but one or a few of the deficiencies are not likely to succeed because they will have insufficient impact upon entrenched traditions of large, complex institutions.

Strengths must be built upon and deficiencies recognized. Corrective measures should proceed along all fronts at once. Only if this occurs, will we build toward a new and happier picture in the ensuing years.

BROADENING THE SCOPE OF EDUCATIONAL PROGRAMS

RECOMMENDATIONS

PRESCHOOL EDUCATIONAL PROGRAMS

PRESCHOOL NURSERY CLINICS

44. Preschool nursery clinics of the Department of Mental Health should be expanded to accommodate all eligible children between the ages of three and seven.

About 400 additional children require such services.

SPECIAL CLASS KINDERGARTEN

45. Joint screening committees should be established, composed of staff from the local school system and the local mental health clinic, to assess a child's readiness for special class kindergartens. Every effort should be made to transfer children from the preschool nursery clinic into the public school preprimary classes at the earliest possible time consistent with their needs.

46. Special class kindergartens should be established for severely retarded children as part of the statewide kindergarten programs recommended by the Willis Commission Report and by the National Educational Association.

Children may transfer to special class kindergartens from the preschool nursery clinics or enter directly from the community based on an assessment by the joint screening committee.

47. Children who are not ready for special class kindergartens should be provided service in the preschool nursery clinic until they are ready for special class kindergartens but not beyond the age of seven.

DAY CARE PROGRAMS

48. The Department of Mental Health should establish day care programs for children who, at the age of seven and thereafter, are assessed by a joint screening committee as not ready to adjust to a public school classroom.

Children may transfer to such day care programs from the preschool nursery clinics, from primary special classes or be accepted directly from the community.

HEAD START

49. The state Department of Education and the Commonwealth Service Corps should assist local authorities in vulnerable and high risk areas to secure funds for preschool enrichment programs so that the opportunity for preschool services will be available for those most in need.

ELEMENTARY AND SECONDARY EDUCATIONAL PROGRAMS

EARLY CASE FINDING

50. To discover existing or potential learning disorders as early as possible, all primary school age children should participate in a group screening during kindergarten or first grade.

51. Multidisciplinary teams should be employed to provide individual evaluation to school children found to have learning and personality disorders.

Approximately 20,000 children per annum may require such evaluation at a projected annual expenditure of $2.3 million dollars.

Sufficient funds should also be made available for additional professional consultation where indicated.

SPECIAL CLASS PLACEMENT

52. Additional factors such as social development should be stressed in addition to the I.Q. in the determination of class assignments. Multiple determinants for class placement are not in sufficient use at this time. The classification of trainable and educable students in Regulation 5, pursuant to Chapter 71, Section 46 of the General Laws should be changed to reflect this view.

EXCLUSION FROM SCHOOL

53. No educable or trainable retarded child classified under the provisions of General Laws, Chapter 71, Section 46, should be excluded from or denied the right to attend public school without formal action by the school committee. The school committee should notify the parent, guardian or custodian of the child immediately concerning the action taken, giving the reasons in detail.

The state Board of Education should rule on the maximum length of time a child may be suspended from school on this basis.

COMPOSITION OF SPECIAL CLASSES

54. Maximum enrollment in an educable class should not exceed 15 students. Regulation 10, pursuant to Chapter 71, Section 46, of the General Laws should be so altered.

55. Maximum enrollment in a trainable class should not exceed 10 students. Regulation 11, pursuant to Chapter 71, Section 46 of the General Laws should be so altered.

56. The maximum age range in any given educable class should not exceed three years, whenever possible.

57. The maximum age range in any given trainable class should not exceed four years, whenever possible.

LENGTH OF SCHOOL DAY

58. All classes for retarded students should be in session for the length of the regular school day. Certain children will, by the nature of their age or maturity, require proportionately shorter school hours of attendance.

Regulations providing for a reasonable length of time for travel on school busses should be adopted by the state Department of Education.

59. The Department of Education should be empowered as the sole authority for approving any exceptions to the regulations referred to in recommendations 54 to 58.

PARTICIPATION WITH REGULAR CLASS STUDENTS

60. Classes for educable special class students should be located in the same buildings as regular classes for students that age. Special class students should participate with their contemporaries in the regular grades in subject classes and other school activities whenever feasible.

SEPARATE SPECIAL CLASSES

61. A committee should be established under the direction of the Bureau of Special Education to study whether it is to the advantage of trainable special class students to have separate facilities, or to share facilities with children in educable classes and in regular grades.

62. Emotionally disturbed children, who are not retarded should not be in special classes for the retarded.

This separation should not preclude joint activities for the former group with other special class students and with regular class students as outlined in recommendation 60.

REGIONAL CLASSES

63. Every town having less than five retarded children should provide for their instruction and training under provisions prescribed by the Department of Education.

The permissive legislation pursuant to Chapter 71, Section 46, of the General Laws should be made mandatory.

Regional classes should not exceed a distance of 25 miles from any of the participating communities.

SPECIAL EDUCATION UNITS

64. All communities and school districts with six or more special classes should establish a supervisory unit for special education through which special class teachers may receive adequate supervision and the assistance of subject matter specialists.

Communities or school districts which have less than six special classes should cooperatively establish regional supervisory units.

All special class units should be under the direction of a special class supervisor.

One supervisor should not be responsible for more than 10 special classes, his assistant(s) for no more than 15 special classes.

QUALIFICATIONS OF SPECIAL CLASS SUPERVISORS

65. All special class supervisors should have training and experience in the field of special education and have fulfilled the requirements for certification as a special class teacher.

SPECIAL CLASS CURRICULUM

66. All communities should be required to develop and submit a special class curriculum and child study plan to the Department of Education for its approval.

67. Regional curriculum study groups should be expanded by the Bureau of Special Education in cooperation with specialists in universities and colleges and with appropriate staff representation from local school systems.

68. Curriculum guides to provide broad direction and stimulation for the development of special class curricula throughout the Commonwealth should be developed by the Bureau of Special Education.

GRADUATION

69. All special class students, who successfully complete the requirements of their school, should participate equally in their school's graduation exercises and receive an appropriate diploma.

VOCATIONAL TRAINING

70. All special class students should be evaluated by a multidisciplinary professional team between the ages of 11 and 13 and periodically thereafter to determine their vocational potential.

71. An occupational specialist should be added to the regular school staff for every 75 special class students above the age of 12 years.

Eighty-five vocational specialists are needed at an approximate annual cost of $550,000.

72. Work study programs should be developed to actively seek more work stations within the school or part-time employment in the local community for special class students while they are still attending school.

73. Schools should provide appropriate adult education for special class students after they leave school in the areas of vocational skills and leisure time activities.

74. Schools should assume responsibility for referring special class students to services they may require after they leave school.

To carry out this function, schools must develop closer working relations with the state and local agencies involved, such as the Massachusetts Rehabilitation Commission and the Division of Employment Security.

CERTIFICATION OF SPECIAL CLASS TEACHERS

75. A new procedure should be developed by the Bureau of Certification and Placement of the state Department of Education which allows for the evaluation of the professional aptitude of applicants for certification as special class teachers as well as their academic qualifications.

There should be no change in the procedures for certifying teachers from out of state.

CERTIFICATION OF SCHOOL PSYCHOLOGISTS

76. Existing certification standards for school psychologists should be reevaluated by a committee composed of representatives from the Department of Mental Health, Education and selected college and university programs to raise the qualifications of psychologists.

This committee should also investigate the feasibility of a new position of assistant school psychologist to help relieve existing shortages in this field and make possible the realignment of current professional responsibilities.

EDUCATIONAL RESEARCH

77. Educational research in areas such as basic learning processes, the development of effective remedial techniques, classroom procedures, methods of instruction, appropriate curricula and special materials should be stimulated by the Department of Education with new information receiving wide dissemination and being translated into practical application within the programs offered.

EDUCATIONAL PROGRAMS AT REGIONAL RESIDENTIAL CENTERS

PERIODIC EVALUATIONS

78. Multidisciplinary teams from the fields of education, psychology, medicine, social work and rehabilitation should make individual evaluations of the learning potential and progress of all residents of regional centers at three year intervals while they are attending school, and periodically thereafter.

Additional staff required will cost approximately $164,000 annually for the four regional centers.

EXTENT OF EDUCATIONAL SERVICES

79. Academic, social, recreational and leisure time activities, and where appropriate, vocational skills, should be taught regularly to every resident, between the ages of three and 21, except for special cases. This instruction should vary with the nature of the residents' abilities, the results of periodic evaluations and the recommendations of staff members who are in daily contact with the resident.

Educational services should be extended to those residents heretofore considered to be ineligible because of severe and profound retardation.

"HOMEBOUND" ACADEMIC INSTRUCTION IN RESIDENTIAL AREAS

80. "Homebound" academic instruction in residential areas should be provided for all residents between the ages of three and 21, if there are no medical contraindications, and residents are nonambulatory, chronically ill or otherwise unable to attend the regular school program.

It is estimated that approximately 400 residents would presently benefit from "homebound" academic instruction at all of the regional centers at an additional annual cost of approximately $150,000.

"HOMEBOUND" SPECIAL SUBJECT INSTRUCTION AND THERAPY IN RESIDENTIAL AREAS

81. Special subject teachers, as well as speech and hearing specialists, occupational therapists, physical therapists, recreational therapists and child development personnel should play a major role in the instruction and therapy of residents who are confined to their living areas, both by direct work with them, as well as by instructing attendants in carrying out some of these skills.

It is estimated that approximately 1,600 residents would presently benefit from "homebound" special subject instruction and therapy at all of the regional centers at an additional annual cost of approximately $250,000.

82. Every attempt should be made to provide adequate room for instruction and therapy

in residential areas, provided such use of the area will not deprive other residents of space needed for social living activities.

CLASSES FOR EMOTIONALLY DISTURBED CHILDREN

83. Educational services should be made available for children who suffer from disabilities in addition to retardation, such as emotional disturbance.

Approximately 16 teachers should be employed to work with emotionally disturbed children in all of the regional residential centers at an approximate annual cost of $100,000.

EXCLUSION FROM SCHOOL

84. Children should not be excluded from school or other forms of educational services without the written approval of the superintendent of the regional residential center, based upon the complete evaluation and recommendations furnished by the Assistant Superintendent for Social Development, Education and Training. Children who are excluded should be reevaluated periodically to determine their readiness for readmission to the school program.

MAXIMUM USE OF NEARBY SCHOOL SYSTEMS

85. As many residents as feasible should attend classes in the public schools of neighboring communities.

The Departments of Mental Health and Education should jointly work to implement this recommendation with the appropriate local school representatives.

86. The Commonwealth should assume responsibility for reimbursing expenses incurred by local communities (for #85 above) by reimbursing them 100% for tuition expenses.

87. The Commonwealth should assume responsibility for reimbursing expenses incurred by local communities (for #85 above) by reimbursing them 100% on a prorated basis, for the cost of capital construction for special classes for retarded children through the School Building Assistance Commission, Massachusetts Department of Education.

CLASSROOM NOMENCLATURE

88. Classroom nomenclature should be uniformly reclassified based on the following approximate chronological age divisions. Flexibility in placement should be retained.

	Years
Nursery	3–7
Primary Educable	7–10
Primary Trainable	7–10
Intermediate Educable	10–13
Intermediate Trainable	10–13
Prevocational Educable	13–16
Prevocational Trainable	13–16
Vocational Educable	16–21
Vocational Trainable	16–21
Adult Education	21 or older

CLASSROOM COMPOSITION

89. Maximum enrollment in nursery, primary educable and primary trainable classes should usually not exceed 10 students, or 12 students if an assistant is available.

If classes have wide age ranges (more than 3 years) or children with multiple handicaps, maximum enrollment should be appropriately reduced.

90. Maximum enrollment in intermediate educable and trainable, prevocational educable and trainable, and vocational educable and trainable classes, should usually not exceed 12 students, or 15 if an assistant is available.

If classes have wide age ranges (more than 4 years) or children with multiple handicaps, maximum enrollment should be appropriately reduced.

91. The maximum age range in any given nursery, primary educable or primary trainable class should, where possible, not exceed three years.

92. The maximum age range in any given intermediate educable, intermediate trainable, prevocational educable, prevocational trainable, vocational educable and vocational trainable classes should, where possible, not exceed four years.

LENGTH OF SCHOOL DAY

93. All curricula for nursery students should be a minimum of three hours per day, excluding travel time.

Exceptions may be made by the Assistant Superintendent for Social Development, Education and Training for those children who may require a program of reduced length.

94. The curricula for all other students should be the length of a full school day.

Exceptions may be made by the Assistant Superintendent for Social Development, Education and Training for those children who may require a program of reduced length.

ENLARGED FACILITIES AND STAFF

95. School facilities should be increased in size and educational and training staff supplemented to accommodate students in smaller classes, as well as for a longer school day. (Recommendations #89–94).

No additions to old and inadequate existing school buildings are intended by this recommendation.

It is estimated that an increase of between 25% and 33% will be required in the size of the educational and vocational training staff at an approximate annual cost of $250,000–$300,000 for all of the regional centers.

ADULT EDUCATION

96. Adult education should be provided regularly for all residents above the age of 21, except for special cases, consisting of academic, vocational and social skills commensurate with the residents' interests and level of abilities.

It is estimated that approximately 2,500 adult residents would benefit from adult education at an approximate annual cost of $270,000–$300,000 for staff for all of the regional centers.

CURRICULUM

97. Curriculum guidelines for the regional centers should be developed by appropriate staff within the Department of Mental Health and the Department of Education.

98. The Assistant Superintendent for Social Development, Education and Training should convene and be responsible for the ongoing meeting of curriculum study groups at each of the regional centers, to help determine the most appropriate content and the most effective methods for assessing and imparting academic, vocational and social skills.

One focus of curriculum study groups should be to help teachers to work with the increasing number of severely retarded residents.

CASE CONFERENCES ON CHILDREN

99. Regular case conferences about individual children should be conducted by all staff persons who have an interest in and knowledge about the child being discussed. The child's current teacher and ward personnel should be included.

Outside consultants should be invited to deal with certain specific issues and problems.

SCHOOL PSYCHOLOGISTS

100. Certified school psychologists should be included on the educational staff of each regional center to work directly with pupils, teachers and administrators and to participate in educational research.

One school psychologist is needed per regional center at an annual cost of approximately $40,000 for the four regional centers.

SUBSTITUTE TEACHERS

101. Funds should be available for each regional center to hire substitute teachers when regular teachers are ill, or are participating in curriculum study groups, case conferences on children, working with students on the wards and attending special conferences and institutes.

About 15 substitute teachers would be needed by the four regional centers at an approximate annual cost of $100,000.

SPECIAL SUBJECT TEACHERS

102. A job category for the following special subject teachers should be established at each of the regional centers according to the following approximate teacher-pupil ratios based on the school age enrollment (ages 6–21).

Art	1:150
Home Economics	1:150
Industrial Arts	1:150
Music	1:300
Physical Education and Recreation	1:150
Language	1:75
Speech	1:75
Reading	1:75

On the basis of present school enrollment at the regional centers (1,667), 120 special subject teachers and therapists are needed at an approximate annual cost of $600,000 for all state schools.

VOCATIONAL TRAINING

103. Vocational potential and future training requirements for academic, vocational and social skills of all residents should be evaluated by a multidisciplinary team when residents are about 12 years old and periodically thereafter (See #78).

104. School-work programs should be expanded to provide realistic work experiences within the regional center for younger residents while they are still attending school.

105. The Assistant Superintendent for Social Development, Education and Training and the Assistant Superintendent for Management should coordinate the educational and vocational programs, as well as the placement and follow-up of the residents among the school department, vocational training department, social service department, and the Massachusetts Rehabilitation Commission.

AFFILIATION WITH COLLEGES AND UNIVERSITIES

106. Every regional center should actively promote affiliations with colleges and universities for the development and expansion of student-teacher training programs, inservice training of teaching staff and other personnel, consultation and collaborative research in curriculum content, teaching methods and teaching aids which will be effective in working with more severely retarded residents.

MATERIALS AND EQUIPMENT

107. An allocation of an average of $750 per classroom should be budgeted annually for consumable supplies and equipment.

JOB SPECIFICATIONS

108. A committee composed of representatives from the unions, professional associations, and the departments involved should participate in the review of job specifications of all personnel at the regional centers and recommend appropriate changes to the Division of Personnel and Standardization based on the effect of newly created job slots and changes in the educational and vocational goals for many of the residents.

SALARIES AND INCREMENTS

109. Specific salary increments should be provided for those teachers and training personnel who have completed advanced graduate work, as is the case in public schools.

110. All education and training personnel with appropriate experience in public or private schools in Massachusetts and in other states, should receive credit for such experience and be placed at the appropriate position of the salary schedule.

QUALIFICATION OF TEACHERS

111. Classroom teachers at the regional centers should be certified in special education by the Bureau of Teacher Certification and Placement. Special subject teachers should be certified in their special subjects and be encouraged to increase their professional background in retardation.

ROLE OF THE STATE DEPARTMENT OF EDUCATION

112. The State Department of Education should assume responsibility for the certification of institutional school teachers and through the Bureau of Special Education, should provide consultation services, and resource information on curriculum, texts and training aids. Four additional senior supervisors would be required to carry out the intent of this recommendation at an additional annual cost of approximately $40,000.

CLERICAL STAFF

113. Clerical services should be provided to administrative, line or consultative staff who have responsibilities in the areas of education and vocational training, to enable them to give more of their time to direct educational and training tasks.

CONSTRUCTION OF EDUCATIONAL FACILITY AT PAUL A. DEVER

114. A centrally located school building is needed at the Paul A. Dever regional center to replace school facilities presently distributed in a number of different buildings presenting many educational and administrative problems. This building should include facilities for a library and a gymnasium, an audio visual and science center and specialized areas for homemaking and industrial arts and provision for psychological, speech and hearing services.

MAJOR REQUIREMENTS

Significant changes have taken place in the education of retarded children in Massachusetts during the past decade. Enrollment in special classes for the retarded increased from 8,393 to 13,562 during this period. Three hundred and one cities and towns were providing special class programs as of June, 1966.

In fiscal 1965, state reimbursements to local communities for special classes for the retarded approximated $4.5 million, and combined state and local expenditures amounted to approximately $9 million.

Despite recent gains, a number of major requirements must be met if every retarded child in every community in the Commonwealth is to receive adequate educational services. These include:

- Early identification and comprehensive evaluation of retarded children within the school system.
- Provision of educational services to every school age person in Massachusetts regardless of condition.
- Employment of about 800 additional teachers.

In the next decade the greatest demands on local school systems and the Department of Education, in respect to special class services, will be increasing enrollments, expanding programs in the kindergartens and in vocational and workshop services.

To provide these educational services, expenditures should more than double within the next 10 years. Total annual operating expenditures for early identification of learning problems and for public school special class programs will amount to about $20 million.

A beginning has been made at state residential schools in the teaching of academic, vocational and social skills to more severely retarded residents, to adults and to others who did not participate previously because of physical disabilities or other chronic conditions. Many school age persons in the state residential schools are still not receiving educational services.

Present appropriations for educational programs in the four state residential schools total slightly over $1 million, or less than one-half the average expenditure for pupils in public school special classes.

An urgent need exists for the expansion of social, academic and vocational training to include residents confined to their wards as well as those who have not now been able to participate in educational programs for other reasons.

To achieve the optimum effect on the integrated functioning of those in institutions, special subject instruction, recreation, speech, vocational and occupational therapies should be integrated into the educational process.

Proposed improvements in educational programs at state residential facilities will require an additional annual expenditure of $2 million above the current annual expenditure of approximately $1 million.

PRESCHOOL EDUCATION

To the best of our present knowledge, early identification, assessment and services may prevent or alleviate later learning problems. Therefore, statewide programs for the evaluation of preschool children, as well as preschool services, should be made available.

PRESCHOOL NURSERY CLINICS

In 1957, Massachusetts became the first state to establish a preschool nursery clinic program. These clinics provide services for children, ages three through six, who generally test on a trainable level at time of entry. Most nursery school clinics are affiliated with local mental health centers, making it possible for professionals in a number of different fields to collaborate in the evaluation. The program is designed to improve the child's social functioning, his self care skills and his readiness to function in a public school setting. Counselling services are provided for parents.

A mandate for expansion of the preschool nursery clinic program was expressed by the General Court in 1966, with the passage of H 3221, amending C. 123, § 13B of the General Laws.

This legislation makes the establishment of preschool nurseries for retarded children mandatory in any city or town where six or more children are eligible for admission. The act also provides for free transportation to and from the nursery school.

On the basis of current waiting lists and the estimated need of areas presently not covered by the preschool nursery clinic service, facilities for an additional 400 children are needed.

SPECIAL CLASS KINDERGARTENS

One of the most important considerations in a child's readiness for special classes in the primary grades is his social and self care skills. Chronological age is a secondary factor, although it is often an administrative consideration.

Some children find the adjustment to a special class difficult. Special class kindergartens are recommended as a transitional program for children transferring from preschool nursery clinics and particularly for those who have had no prior nursery school experience.

Special class kindergartens should be available in all communities for children at about the age of four and one-half or five, the same as for other children.

To assure appropriate placement, joint screening committees should be established, composed of staff from the local school system and the local mental health clinic.

These joint screening committees should be responsible for recommending the transfer of children from preschool nursery clinics to special class kindergartens. They should also assess a child's readiness for special class kindergartens when the child enters directly from the community. Children who are not ready for special class kindergartens should be provided service in the preschool nursery clinics until they are ready for special class kindergartens, but not beyond the age of seven. At that time a joint screening committee should assess a child's readiness for special class or recommend his transfer to a day care program.

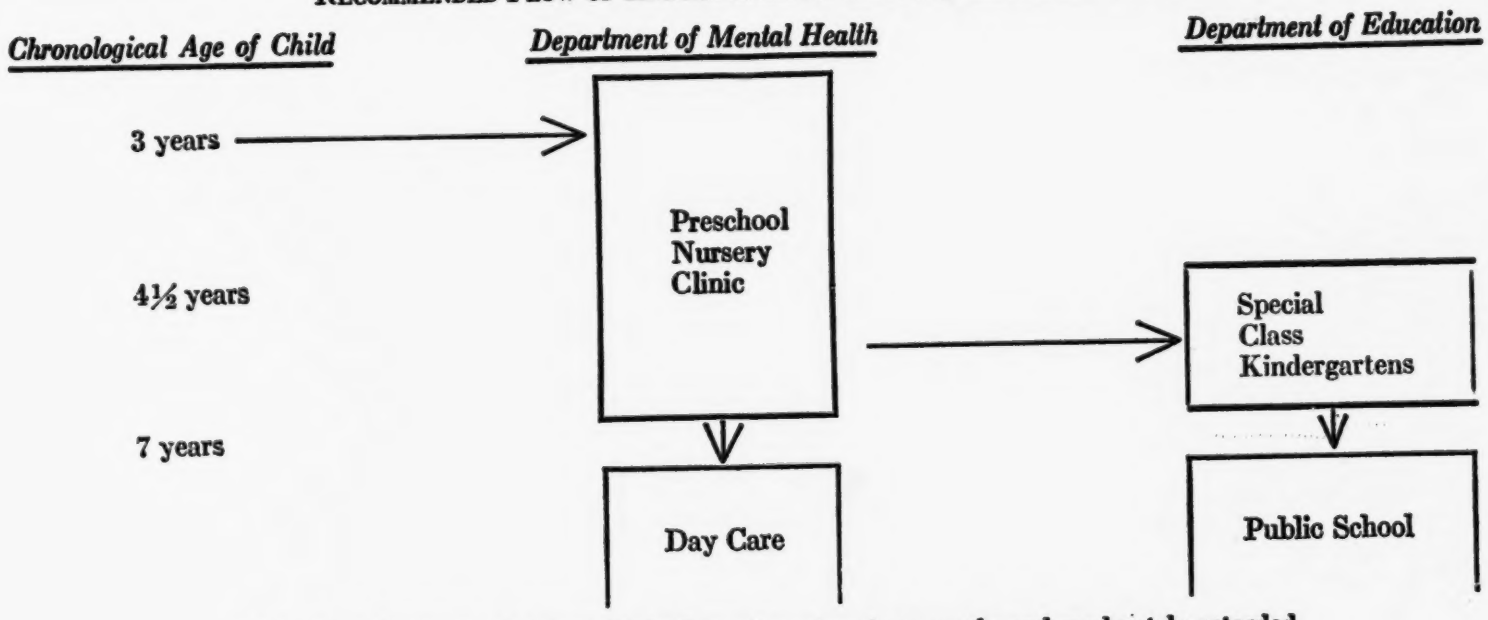
DAY CARE PROGRAMS

Approximately 100 children who reach the age of seven each year are not ready for special classes in the public schools. These include children who have attended preschool nursery clinics, those on preschool nursery clinic waiting lists and those living in areas without preschool nursery clinics.

The Department of Mental Health should establish day care programs for children who, at the age of seven and

FIGURE 1

RECOMMENDED FLOW OF EDUCATIONAL SERVICES IN THE EARLY YEARS*



*This chart illustrates the most likely flow of services for severely and moderately retarded children, and for moderately and mildly retarded children. However, children may enter appropriate services at any point and at any age within prescribed limits.

thereafter, are assessed by the joint screening committee as not ready to adjust to a public school classroom.

Children may transfer to such day care programs from the preschool nursery clinics, from primary special classes, or be accepted directly from the community.

Figure 1 illustrates the flow of services, and the manner in which they should be coordinated between the Department of Mental Health and the Department of Education.

KINDERGARTEN

Every child in the Commonwealth should be able to attend kindergarten starting at the age of four and one-half, as recommended by the Harrington-Willis Commission report. There is general agreement that early educational evaluations and services are likely to be helpful in minimizing later learning disorders.

No conclusive findings are available regarding the most effective curriculum or the best age at which to begin services.

Kindergarten programs should be flexible and a number of different educational models should be designed. These should contain inbuilt mechanisms for evaluation, so that the effect of the method on a certain number of predetermined variables can be evaluated.

Administrative mechanisms should allow professionals working in these programs to exchange information about problems and results at frequent intervals.

ADMINISTRATIVE RESPONSIBILITY

The Department of Mental Health should be responsible for diagnostic and program services in the preschool nursery clinics and in the day care centers. Mainly, the Department should be responsible for those severely retarded and preschool and school age children who are not eligible or otherwise unable to participate in the kindergarten or special class programs conducted by local school systems.

HEAD START PROGRAMS

Public and nonprofit schools and health and welfare agencies should take full advantage of opportunities provided by the federal government to sponsor summer and year around Head Start programs in high risk areas of the Commonwealth.

Evaluative research should be built in at the outset of publically supported preschool programs to discover what facets of the program, in combination, are most responsible for:

- Establishing patterns and expectations of success for the child which create a climate of confidence for his future learning effort.
- Improving the child's mental processes and skills.
- Improving the child's physical health.

The mechanism for establishing statewide preschool programs, evaluation procedures and standards is discussed in the section, *Preventing Retardation; Social and Behavioral Considerations.*

ELEMENTARY AND SECONDARY EDUCATION

EARLY CASE FINDING

Group Screening

Most severely retarded children are identified early. However, mildly retarded children are often not identified until they have repeated the first, second and sometimes the third grade one or more times. A lack of early screening in many school systems in Massachusetts may be partially responsible.

Group screening procedures would seem to be of great value for improving the educational service to the individual child and for deriving information which would help to plan for the future needs of special educational programs. Screening could be administered at the kindergarten or first grade level on a group basis and be followed by an individual evaluation where indicated.

About 75% of the school systems in Massachusetts are presently giving their primary school age children some form of group tests. The grade levels during which these tests are administered vary. However, most systems administer them in second, third and even higher grades.

A few school systems are giving group tests to children in kindergarten and first grade, a trend which is increasing because school systems recognize the importance of the earliest possible discovery of learning problems. A drawback to administering the tests during kindergarten and first grade is that they must usually be reading readiness tests which are considered to be less valid than some of the instruments which can be utilized with older children.

One of the most urgent needs in this area is the development of more valid and reliable instruments which are appropriate for this age group. A variety of group screening models should be used on a trial basis with inbuilt mechanisms for evaluation regarding their predictive capabilities.

Differential Diagnosis

Retardation is often accompanied by other handicaps. Thus, a comprehensive evaluation of a retarded child requires the combined, cooperative efforts of a team of specialists from different disciplines. A diagnosis is not an end in itself, but rather a part of an ongoing clinical process designed to assist the child and his family in making realistic lifelong plans. A comprehensive evaluation by a team of skilled persons will help to describe the child's current functioning, his future potential and will help to indicate the means of remediation and therapy which are likely to be most helpful with the child's current problems.

A child needs a total evaluation by a team of specialists at all ages, although particular specialists may be more important at any given age. The total evaluation approach has particularly demonstrated its usefulness in the development of treatment plans for emotional disturbance, cultural deprivation and extra-pyramidal cerebral palsy. Medical diagnostic findings and treatments are of particular importance with young children in surgical corrections of congenital anomalies, control of seizures, utilization of drug therapy for specific behavior disorders, utilization of diet therapy for certain metabolic disorders of the central nervous system and correction of specific perceptual handicaps. Group tests alone will not be adequate in detecting these and other problems related to learning, or in determining the most appropriate services.

Approximately 100,000 new students enter school in Massachusetts annually. When all of them receive group tests, it is estimated that between 15% and 20% will require a more careful, individualized assessment.

Every school system has the responsibility of providing the appropriate educational services which are based on an adequate assessment, by employing or purchasing the services of a multidisciplinary team composed of a physician, clinical psychologist and a social worker.

To evaluate a maximum of 20,000 primary school age children annually, the equivalent of 52 full time teams would be required throughout Massachusetts. Annual cost would be approximately $2.3 million. Smaller school systems should employ or purchase part time services.

Need for Extensive Diagnosis

Children who appear not to be basically retarded but rather incapacitated by sensory, physical or emotional difficulties are often placed in a special class when other kinds of educational placement or treatment approaches might be better indicated. A good differential diagnosis in these cases is difficult under the best of circumstances. Multiply handicapped children require a team evaluation based on a prolonged period of observation. Some of the communities with more advanced services are relying more and more on allied agencies in the community to assume responsibility for diagnosis and evaluation of multiply handicapped children. Many communities do not have such allied agencies readily available and this constitutes a major problem. There does seem to be a trend towards total evaluation of children who are school failures. However, this is not yet true of all communities in the Commonwealth. When the multidisciplinary team has reason to believe that multiple disorders may be present, they should be in a position to readily avail themselves of professionals, such as a psychiatrist, pediatric neurologist, speech pathologist, audiologist or opthamologist to verify the presence or potential presence of a learning or personality disorder in any child.

Consultants may be drawn from the staffs of the Community Mental Health-Retardation Centers as soon as these are established throughout Massachusetts. Schools in areas where Community Mental Health-Retardation Centers have not yet been established should purchase professional consultation privately or through voluntary agencies in their communities. In addition, the staff of the Community Mental Health-Retardation Center should accept necessary responsibility for securing those community services for the retarded child and his family which are not within the scope of those traditionally provided by the schools.

CLASS PLACEMENT

Definition and Classification

A stated I.Q. score is an implicit predictive statement because of the popularly assumed constancy of the intellect. The lay public, as well as many professional persons, respond as if intelligence is constitutionally determined and unchangeable as eye color. Observations made of a child during a diagnostic evaluation are more than the specific behavioral achievements of the child at the time. The diagnostic team must seek to assess and describe the underlying processes which contribute to the behavioral achievements which they have observed. This point is specifically relevant to the interpretation of intelligence tests. Despite continuous warnings in the professional literature that scores on an intelligence test are often the result of averaging groups of functions, scores of average achievement are often not supplemented by a more careful analysis of the child's functioning.

Special education forms of the Department of Special Education which are required for admission to the special class (SPED — 7, 7a, 7b, 7c, 8, 9, 9a, 9b, 9c, 10, 11) give specific requirements for a wide range of diagnostic evaluations by specialists in medical, educational and psychological fields. These forms are sometimes not fully adhered to and a number of children are admitted to the special class with minimal diagnostic evaluations, which are sometimes performed by personnel with limited training. While the Bureau of Special Education has given thought to the need for a "total child" evaluation prior to admission to a special class, the mechanisms which have been provided are not always carried out at the local level.

The expansion of the factors which presently constitute the definitions and descriptions of different levels of retarded children would be an important step towards full compliance with the intent of the regulations by all school systems.

Therefore, the following revision in Regulation 5, Chapter 71, Section 46 of the General Laws is recommended (changes in italics): Mentally retarded children shall be classified as follows:

A. "The Educable"

These children function at the time of school evaluation: on a psychometric level (as measured by standardized and clinical tests) that is characterized by general inability to succeed in school-related tasks; on an academic achievement level (as measured by standardized and informal tests) significantly below average age performance; without necessarily being impaired in either maturation or school adjustment; and, insofar as is determinable, with learning limitations not associated with symptoms of primary personality or sensory deterioration. Usually such children will receive a score of from 50 to 79 on the intelligence tests approved by the Departments of Education and Mental Health and administered by an examiner approved by said departments. In exceptional cases other children whose educational needs, in the opinion of the superintendent of schools, and subject to the approval of the Department of Education, will be best served by this classification, may be so classified.

B. "The Trainable"

These children function at the time of school evaluation: on a psychometric level (as measured by standardized and clinical tests) that is characterized by general inability to succeed in all problem solving tasks; on an academic achievement level (as measured by standardized and informal tests) without discernible usable skills, frequently impaired in both maturation and social adjustment; and, insofar as is determinable, with learning limitations not associated with symptoms of primary personality or sensory deterioration. Usually such children will receive a score of from 20 to 49 on the intelligence tests approved by the Departments of Education and Mental Health and administered by an examiner approved by said departments. In exceptional cases other children who, in the opinion of the superintendent of schools, and subject to the approval of the Department of Education, will be best served by this classification, may be so classified.

C. "The Custodial"

. . . children who, due to severe mental retardation, are in need of constant supervision and care.

Exclusion from School

No alternative provisions are being made for many of the children being excluded from public school because of retardation, behavior disorders and other justified reasons. Educational services in the Commonwealth should be directed towards the inclusion of all children, regardless of their diversified requirements.

Through the increased use of regional classes, through the enlightenment of school boards regarding this problem and through the education of parents regarding their rights, educational services for atypical children, who at present are excluded, can be enhanced. Therefore, the following revisions in Regulation 5, pursuant to Chapter 71, Section 46 of the General Laws are recommended (changes in italics):

"Educable" and "Trainable" mentally retarded children may be excluded from public schools:

1. If their presence is detrimental to the other members of their class or school.

2. *After their names have been submitted with full case studies citing reasons for their exclusion to an Advisory Board of the local school committee, who after due deliberation approve the exclusion.*

a. Mentally retarded children who are excluded from school shall be reported forthwith to the Department of Education with full case studies citing reasons for their exclusion.

b. *Parents of all children who are excluded from school on this basis must receive a written report citing reasons for their child's exclusion and explicit instructions for filing an appeal, if they do desire.*

It should be noted that no clearly defined line of demarcation can be made between the various classes of mentally retarded children based exclusively on intelligence quotients. It should be noted that children are not classified as mentally retarded solely on the results of an intelligence test, but rather on the results of a multidisciplinary evaluation required by regulation and reported on SPED Forms 7 through 11B.

A report shall be rendered by the Superintendent of Schools to the Departments of Education and Mental Health (Chap. 123, Section 13) on a form approved by the Departments of Education and Mental Health, concerning the results of examinations of each child referred by him for examination for special education. The services of other departments should be made available to children who are excluded from school whenever this is appropriate.

COMPOSITION OF SPECIAL CLASSES

Class Size

Factors which bring about retardation are often responsible for associated disorders including problems of speech, hearing, vision, perception, motor coordination and emotional disturbance. These vary in combination and in intensity, but almost always require that a teacher give students individual attention.

Reduction of the maximum number of students in educable classes from 18 to 15 and in trainable classes from 12 to 10, would permit the special class teacher to individualize instruction to a greater extent than is possible at present.

Age Range

Although the presence of children of widely varying ages in one classroom may be utilized instructively, a wide age range in special classes is usually detrimental. Experimentation with model roles for older special class students should not be ruled out. However, the immaturity, behavior disorders and academic limitations which are found in varying degrees among these students, limit the usefulness of such models. The accomplishments of special class teachers could be greatly enhanced by limiting the age range in any given educable class to three years, and in any given trainable class to four years.

Length of School Day

The length of the school day for special classes is shorter than the school day of regular grades in some communities. Regulation 12, Chapter 71, Section 46 of the General Laws states that " . . . classes for educable mentally retarded shall be the length of the regular school day." This regulation should be more stringently followed.

School days of two and a half hours were encountered in some trainable special class programs. In these and other instances, the children are receiving less instruction than could possibly be of benefit. Present regulations require that classes for trainable retarded children shall be conducted for not less than two and one-half hours per day. This should be increased to a minimum of four hours, with variations for individual students based on their development and the specific curriculum of the class.

Integration with Regular Class Students

A number of school systems assign retarded children to segregated placements in special schools set aside for retarded youngsters. It may be true that there is no evidence either confirming or denying the superiority of segregated schools in contrast with special classes within regular schools. Retarded children can, however, benefit from integration with more typical peers. The segregation of these children in special schools deny all possibility for this to take place. Conversely, the integration of children into regular schools will not guarantee the development of real associations and friendships between retarded youngsters and more typical learners. Nevertheless, this integration makes it possible for these associations to be made when the circumstances are fortuitous and all other conditions are working in favor of the special class children. Secondly, the segregation of special class children in special schools also causes their teachers to be segregated from colleagues in the other fields of education. A segregated school provides certain advantages insofar as grouping of children, collecting together groups of professional personnel interested in retardation, and in shielding teachers and children from the barbs and unkindnesses that may be encountered in the regular school setting. However, a weighing of all factors — pro and con — leads to the assumption that the segregation of children into specialized schools is deleterious both for these children and their teachers, even in the best of all situations.

Classes for educable special class students should be located in the same buildings as regular classes for students that age at all times. Whenever feasible, special class students should participate with their contemporaries in the regular grades, in subject classes and other school activities.

The ongoing efforts of the Bureau of Special Education and local schools to integrate students in educable classes with students in regular classes where feasible, is to be commended and should be continued and expanded.

Basis for Separate Special Classes

Criteria for admission to special classes for retarded children vary widely across the state. Some schools place children in educable classes without complying fully with the regulations. Expert testimony supported the viewpoint that the I.Q. score appears to be of primary importance, particularly in the placement of educable children in special classes. Acting out behavior and inability to adjust to classroom routines were next in importance as factors in special class placements. As a result many special classes are composed of both emotionally disturbed children and those who are not emotionally disturbed. This is due in part to the lack of a clear differential diagnosis between what is often referred to as "primary mental retardation" and "primary emotional disturbance."

The placement of emotionally disturbed children in the same classes with educable retarded children is detrimental to the progress of either group. All efforts by local schools to provide them with separate classes should receive strong support.

Regional Classes

Special education in the less densely populated rural areas is faced with certain problems which are accentuated more than in urban centers. Wide range of ages and abilities among students, the increased range of responsibilities of special class teachers and infrequent supervision and limited

professional contacts are just a few. Special class services for students living in rural areas are not fully available and some potential special class students may not receive adequate services. There are also fewer opportunities for vocational training and job placement, particularly in areas which may be economically depressed.

Permissive legislation allows school committees to join with other communities in establishing regional classes for educable and trainable retarded children where there are fewer than 10 such children in the community. As of June, 1965, 68 cities and towns in 23 regional school districts had cooperative arrangements. Some additional communities paid for the education of their special class students in other school systems. The lack of special class services is particularly acute for high school age students, who frequently share classrooms and programs with children half their age.

Progress in establishing regional special classes in Massachusetts has been encouraging. Ten new cities and towns participated during the last year. The trend has been definitely established and the urgency of providing special education services for all children is clearly recognized. Therefore, it appears to be timely to recommend that the permissive legislation of Chapter 71, Section 46 of the General Laws be made mandatory and changed as follows (changes in italics):

Every town having less than five mentally retarded children shall provide for their instruction and training under provisions prescribed by the Department of Public School Education.

This provision shall be inserted in place of the permissive legislation in Chapter 71, Section 46 of the General Laws.

No regional class shall exceed a distance of 25 miles from any of the participating communities.

That portion of the educational expense not borne by the state, should be shared on a prorated basis by each of the participating communities. The cost for transporting children to and from these regional classes should be reimbursed to the communities by the state Department of Public School Education.

Open Door Policies

Educational programs, even for normal children, require flexibility to meet individual needs. Therefore, what is referred to as the "open door policy" in a special education program is most appropriate. As a result of this policy, placement in any special program is not viewed as permanent. On the other hand, the "open door policy" should not be a "swinging door policy." A special educational program should play a particular role in the child's educational development. To achieve this both the child and the special class teacher need a given period of time to work together so that the child can utilize what the classroom situation has to offer and the teacher and others can assess the child's adjustment in this particular setting.

Periodic reevaluations for retarded children are required by state law every two years. These periodic evaluations usually consist of only an intelligence test. Although periodic evaluations protect the retarded child from improper placement in the special class, careful continuous evaluation would be more appropriate. Any diagnostic procedure should be performed with the goal of aiding in the continuous understanding of the individual child and for the planning of programs appropriate to his requirements. Much valuable information in reevaluations can be gained from the special class teacher because of her prolonged and varied experience with the child.

SUPERVISION OF SPECIAL CLASS TEACHERS

Few individuals, assigned from local public school systems, have major responsibilities for the supervision of special class teachers. School principals often feel themselves to be inadequate to offer specialized curriculum guidance and direction. Although some communities have individuals serving as "supervisor of special education" or "director of special education," these people are most often assigned many other responsibilities (e.g. director of psychological testing, curriculum coordinator, elementary supervisor). Therefore, they are either unable or unwilling to devote a great deal of time to the special class program. Frequently, the "director of special education" is director in title only. Either because of prior training (which may be little if at all associated with the field of special education) or a multiplicity of professional assignments, this director is often unavailable for specialized supervision. The six special class supervisors on the staff of the Department of Public School Education have too many responsibilities to offer the day-by-day supervision many teachers, especially inexperienced ones, need and frequently want. It would be fair to state that a great many special class teachers in Massachusetts are receiving little, if any, specialized supervision and infrequent general supervision. This lack of appropriate supervision and support often leads to discouragement and anxiety, coupled with the isolation of "being alone." With new and inexperienced teachers, these conditions can conceivably result in premature resignations or shifting to other fields of education. Probably most discouraging of all could be the development of mental sets and attitudes tending toward self-defeating behavior, both from the viewpoint of the teacher and her development, as well as that of the children.

In addition to a lack of adequate supervision of many special class teachers, there is the problem of providing special class students with adequate time from subject matter specialists.

A very high percentage of retarded children have speech, language, hearing and vision disorders. Oftentimes, individual assistance is necessary if the child is going to modify or overcome these additional handicaps. Frequently this assistance is not available. Specialists serving in these auxiliary fields usually have caseloads covering the entire school population. There is a tendency to schedule the retarded child, if time allows, after most of the other children requiring special help have received it.

Special Education Units

Establishment of administrative units for special education should be a means of bringing help to both of these problems. By providing a director of special education for every six special classes, adequate supervision for special class teachers should become a reality. Rural areas and smaller communities should establish such units cooperatively for every six special classes.

The director of the "cooperative" special education units should be employed directly by the Bureau of Special Education so that tenure in any of the cooperating communities will not become a problem. Local communities should reimburse the state for their share of the unit director's salary.

Services of subject matter specialists should be available to the director of the special education unit for an adequate number of hours throughout the school year. He could assign specialists to those classes most in need of the services.

In addition, the special education unit should be able to purchase consultation from other professionals in the community whose services may be required.

All special class supervisors should have training and experience in the field of special education and should have fulfilled the requirements for certification as special class

teachers. This would enhance the ability of the directors of special education to fulfill their responsibilities adequately.

SPECIAL CLASS CURRICULUM

Curriculum Development

Only a few active curriculum development groups are meeting regularly and coming to grips with the complex responsibility for designing adequate curricula for the retarded. Responsibility for curriculum development must reside in the cooperative development of a curriculum involving teachers, supervisors, psychologists, and other professional personnel concerned with the education of retarded children in particular communities. It is unsatisfactory for "outside agencies" to develop curriculum guides and present these to local communities for their implementation. The strength of a curriculum and the development it achieves is not particularly vested in the final document but rather with the deliberations that provide the process during which the curriculum is developed.

The Division of Special Education should develop permissive curriculum guides that offer broad directions and stimulation for the development of special class curriculum throughout the Commonwealth. Simultaneously, regional curriculum study groups should be greatly expanded by the Division of Special Education in cooperation with specialists in universities and colleges, as well as appropriate staffs from local school systems.

Based on the work of regional curriculum study groups, in which local school personnel have participated, all communities should be required to develop and submit a special class curriculum and child study plan to the Department of Public School Education, for its approval at least every five years.

The staff of six state special class supervisors should be increased to 10 to help communities in the preparation of these plans and in the correction of any deficiencies.

PARTICIPATION IN GRADUATION

There is great variation in the policies of many school principals regarding the participation of special class students in graduation exercises. All special class students who successfully complete the requirements of their school, should participate equally in their school's graduation exercises and receive an appropriate diploma, in recognition of the importance of the occasion and of their equal status.

VOCATIONAL REHABILITATION

Evaluation of Vocational Potential

Classroom composition is often uneven, including a wide age range and wide discrepancies in manual skills, emotional stability and learning motivation. It is difficult to determine which curriculum will be most effective in preparing special class students vocationally and which additional services specific students may require. This question becomes particularly critical around the age of 12 when work habits and social and vocational skills should start to predominate in the curriculum. To allow students to participate in a curriculum most in keeping with their capabilities, a complete evaluation of their vocational potential should take place at that time.

Currently, many schools do not give sufficient attention to the development of vocational skills. A greater effort should be made to integrate prevocational subjects into the curriculum and to realistically relate the school curriculum to the ultimate vocational responsibilities of special class students.

Addition of Occupational Specialists

If the goal of special classes is to prepare students for eventual employment, changes will be necessary. Classroom composition and curriculum need to be altered and special class teachers should receive additional training and consultation in the area of vocational preparation. Most special class teachers are involved in a number of activities on behalf of their students in addition to their teaching responsibilities. Tasks such as remedial reading, student counselling, work with parents, the development of vocational plans, job finding and follow up should be the major responsibility of specially designated personnel.

It is of basic importance that special class teachers are provided with enough help so that they can devote their time and effort to teaching. French, science or math teachers are not expected to deal with students' problems which are beyond their skills. Neither should a special class teacher perform the functions of other specialties. In the vocational area, the special class teacher should receive consultation with the curriculum, the assignment to work stations in the school, part time work in the community while still in school and job finding and follow up.

Fulfillment of these responsibilities on behalf of special class students is most important if they are not automatically to be relegated to marginal types of employment. One occupational specialist should be added to the regular school staff for every 75 special class students, 12 years and older. On the basis of present school enrollment, approximately 85 occupational specialists are needed in school systems and regional districts throughout Massachusetts at an approximate annual cost of $700,000.

The occupational specialist should have a good background in both education and vocational rehabilitation and a knowledge of training and placement resources and how they may be used. His work experience should include either education, special education or vocational counselling. His training should be on a master's degree level and supplement the field of education or vocational rehabilitation in which he may not have had direct experience.

Responsibilities of Occupational Specialists

The occupational specialist should have the responsibility to coordinate the vocational training of up to 75 special class students age 12 and over and to put into effect and follow up the recommendations of the joint staff committee, who conducted the evaluation. He should refer students to specialists in other disciplines as the need may arise. It will also be his responsibility to identify and coordinate work stations within the school system, to work with some employers in the community to provide job try-outs, to act as liaison with the vocational rehabilitation agency counselor, make referrals to him for training and for community job placement, and provide him with the necessary information about each student.

The occupational specialist will be administratively responsible to the special class supervisor, who directs the special education unit to which he is assigned.

POST SCHOOL SERVICES

The Commonwealth has seen fit to invest many millions of dollars annually in the higher education of its gifted citizens. The effectiveness of post school services for special class students in achieving their highest potential is far less well known and the financial and manpower investment comparatively very small.

Until we gain in knowledge regarding effective services for special class students as related to their adjustment as adults

in our society a variety of service models should be tried and carefully evaluated.

Minimal post school services should permit special class students to continue in school as long as regular class students, a practice which is being increasingly adhered to throughout the state.

For special class students who may need to stay beyond that time, a functional curriculum must be developed on the level of adult education which would be useful and interesting to students that age. Efforts in this area by the Division of Special Education should be continued and expanded.

Greater use must also be made of community resources for job placement and follow up. At present, there does not appear to be a clear understanding on the part of special class teachers of the functions of the Massachusetts Rehabilitation Commission and the Division of Employment Security. Occupational specialists should help to stimulate the flow of referrals to such agencies and make it possible to refer all students who are unable to find employment and may benefit from additional training and extensive job placement facilities.

CERTIFICATION

Certification of Special Class Teachers

Teaching retarded children requires technical knowledge, specialized teaching methods, knowledge of community agencies and the understanding of the contribution of other professions in coping with the problems often associated with retardation.

In addition, the teacher's ability to relate and to motivate the children, patience and a sense of humor are perhaps most important. Teachers should also show capability of being able to profit from a supervised classroom experience.

If the best possible teachers are to be certified in the field of special education in Massachusetts, certification should be based not only upon the subject matter they have successfully covered, but upon a close knowledge of their ability to apply this material, over time, in an actual teaching situation.

The college or university preparing the student in special education is in an unequalled position to judge his qualifications for the field. The Bureau of Teacher Certification and Placement should authorize universities and colleges in Massachusetts who meet the Bureau's qualifications, to submit to the Bureau the names of their qualified students for certification by the Bureau.

The Division of Special Education should give consultation and assistance in order for more colleges and universities in Massachusetts to become eligible to submit their students' names for certification by the Bureau.

All special class teachers should be certified in this manner by July 1, 1971.

This change is also seen as a means of stimulating the expansion of special education teacher training programs in all regions of the Commonwealth.

When facilities for training special class educators become fully available throughout Massachusetts, it will become feasible to require candidates for certification to take a program which is under the supervision of one college or university authorized to recommend its students for certification. Candidates may, with the approval of this college or university, take courses in more than one school, so long as their over-all preparation is under the supervision of only one school.

No changes are recommended in the procedures for certifying teachers from out of state.

Educable and Trainable Classes in Massachusetts Public Schools — 1965

Retardation Area	Special Class Enrollment		
	Educable	Trainable	Total
Central Region			
Boston University*	669	60	719
Brookline-Brighton*	293	28	321
Government Center*	484	47	531
Grafton	175	29	204
Medfield	269	60	329
Newton	156	46	202
Roslindale*	450	40	490
South Shore	493	86	579
Tufts*	270	25	295
Westborough	278	43	321
Northern Region			
Beaverbrook	244	46	290
Cambridge	356	39	395
Concord	21	13	34
Danvers	335	54	389
Haverhill	233	11	244
Lawrence	257	26	283
Lowell	363	46	409
Lynn	365	44	409
Malden	208	49	257
Mystic Valley	165	40	205
Reading	154	28	182
Southern Region			
Barnstable	284	4	288
Brockton	508	58	566
Fall River	486	23	509
Foxborough	134	29	163
New Bedford	446	62	508
Plymouth	137	19	156
Taunton	205	22	227
Western Region			
Berkshire	203	32	235
Fitchburg	342	46	388
Franklin	170	21	191
Gardner	162	9	171
Holyoke	218	50	268
Northampton	82	9	91
Southbridge	194	17	211
Springfield	1,033	81	1,114
Worcester	535	44	579
Totals	11,377	1,386	12,763

*Estimated distribution of Boston special class enrollment of 1,920 educable and 157 trainable pupils.

Source: Massachusetts Department of Education, June, 1965.

Certification of School Psychologists

Psychological testing requires great flexibility of approach, particularly when dealing with handicapped children. The psychologist must be familiar with a wide variety of tests to deal with the evaluation of children of different ages and different developmental levels. It was noted that such flexibility in training and experience was sometimes absent among the individuals doing testing in the schools. Despite the fact

that the Department of Special Education requires that testing be performed by certified school psychologists, it is sometimes being done by less trained personnel, in one brief testing session rather than in a more systematic longer evaluative process.

Although school psychologists are becoming available in increasing numbers, many have had only a bare minimum of professional background. The situation is made more complex by the fact that often their caseloads are so extensive that they simply do not have the time to do appropriate individual evaluations. Most of these individuals have had little work or course background dealing with retarded children. Most guidance specialists or school psychologists in the Commonwealth cannot be considered experts in the psychological assessment of retarded children.

A committee composed of representatives from the Department of Education, the Department of Mental Health and selected colleges and universities should reevaluate the certification standards of school psychologists. These standards should be studied in regard to the recommendations of the Division of School Psychologists of the American Psychological Association.

Communities unable to secure the full time services of a trained psychologist should arrange for consultation services. Consultants could supervise the testing done by local personnel and participate on the professional team making referrals for placement.

Certification of Assistant Psychologists

The position of assistant psychologist should be created to help relieve the serious shortage of personnel in this field. The committee recommending certification standards for psychologists should also develop certification standards for assistant psychologists.

Assistant psychologists should work under the supervision of psychologists in testing and in reevaluating special class students. The decision to place a student in a special class should only be made with the participation of at least one fully certified psychologist.

EDUCATIONAL PROGRAMS AT THE REGIONAL CENTERS

NEW PATTERNS

Significant changes are underway in the education of residents at the regional centers for the retarded.* Academic, vocational and social skills are taught as closely related areas recognizing that the extent to which a resident participates in the life of the regional center or in the community depends on his ability to integrate all these skills in individualized programs. Educational services are beginning to be made available to more severely retarded residents, as well as to others who did not participate previously because of physical disabilities or other chronic conditions. An increasing number of classes are being formed for adults.

As education and training is made available to the severely retarded and multiply handicapped the following related developments should take place:

- Research and demonstrations to aid in the development of appropriate teaching techniques, "classroom procedures" and curricula.
- Reorientation and additional training of educational staff.
- Cooperative programming between the educational and nursing service.
- Expansion of educational services to include residents who are confined to the wards.

There is mounting evidence that almost all retardates can profit from instruction in some area. Academic training may not be feasible for many residents. However, they may be able to master certain vocational and social skills. An individualized program based on a thorough knowledge of each resident is needed. The strengths of each individual should be built upon to bring about optimum development.

Programs must be based on thorough evaluations of learning potential and periodic reevaluations, which take cognizance of the individual's past response, and help to provide guidelines for future services.

Evaluations should be conducted by a team of educators, psychologists, physicians, social workers and rehabilitation counselors from the staff of the regional centers, in consultation with ward personnel and other staff who work closely with residents. Team members should also be responsible for interpreting the results of individual evaluations to program staff, and for helping to develop training programs in accordance with the needs identified in the evaluation.

Residents should be formally evaluated approximately every three years while they are attending school (ages three through 21) and periodically thereafter. On this basis, approximately one-fourth of the residents would be evaluated annually (about 500 per regional center). A number of such evaluations are presently being conducted. To meet the additional work load, one physician, one psychologist, one social worker and one rehabilitation counselor should be added to the present staff of each regional center at an annual cost of approximately $164,000 for all four regional centers.

EXTENT OF EDUCATIONAL SERVICES

In June, 1965, there were 3,090 residents, ages 6–18, at the residential centers. Only about 50% of these residents were attending classes. The others were not receiving regular educational services because of severe retardation, multiple handicaps and/or chronic illness and also because of staff shortages and inadequate budgets.

Many residents previously considered to be ineligible for education are now being included in programs commensurate with their abilities. This is particularly important with the increasing proportion of severely retarded residents at the regional centers who can learn a number of functional skills, but may fail to achieve traditional academic and vocational goals.

Academic, vocational and social skills should be taught regularly to every resident between the ages of three and 21, except for special cases. This instruction should vary with the nature of the residents' abilities and the results of periodic evaluations emphasizing each resident's optimum independent functioning.

"HOMEBOUND" ACADEMIC INSTRUCTION

"Homebound" instruction provides for the teaching of academic, vocational and social skills to residents who, because of severe retardation and/or chronic disabilities are

*With respect to existing state schools, the expanded commitment to community oriented services, including consultation, day care, and vocational training, should be reflected in a change in name from state residential schools to regional residential centers for the retarded.

confined to the wards and unable to attend classes. Both academic and special subject "homebound" instruction should be made available. "Homebound" academic instruction in residential centers should be provided for all residents between the ages of three and 21, if there are no medical contraindications and residents are nonambulatory, chronically ill or otherwise unable to attend the regular school program. All residents who are able to profit from group instruction should participate.

Approximately 400 residents would benefit from "homebound" group instruction in all of the regional centers. Decisions for eligibility should be made by a staff team during the periodic evaluations. Special evaluations should be scheduled if the residents' development so indicates.

Work with individual students or in small groups may be necessary since most residents confined to the wards have not had previous instruction. Persons who could be taught together may be unevenly distributed. Present estimates are that each teacher could assume responsibility for a total of 10–15 students. About 25 teachers would be required in all of the regional centers to provide academic "homebound" instruction. Teacher aides should be utilized to maximize remedial and individual instruction. At an average annual salary of $6,000 per teacher, "homebound" academic instruction would cost approximately $150,000 annually.

"HOMEBOUND" SPECIAL SUBJECT INSTRUCTION AND THERAPY

Special subject teachers in music, art, home economics and physical education and recreation, as well as speech and hearing specialists, occupational therapists, physical therapists, recreational therapists and child development personnel, should play a major role in the instruction and therapy of all residents between the ages of three and 21 who are confined to their living areas.

The extent and type of special subject instruction and therapy will have to be determined on an individual basis and will vary considerably from resident to resident.

All residents should be involved in a variety of areas at a level at which they are able to participate. Considerable experimentation with each resident may be necessary to determine the activities they can best utilize. This will require direct work by teachers and therapists with individuals and in small groups. Every effort should be made to instruct attendants in carrying out some of these skills thereby making some instruction and therapy available to residents on a continuing basis.

Approximately 1,600 residents, or four times as many as could benefit from an academic program, would presently benefit from "homebound" special subject instruction and therapy.

It is difficult to estimate the number of teachers and therapists who would be required for direct work with residents and for the instruction and supervision of ward personnel. Therefore, a staff team of specialty consultants in art, home economics, industrial arts, music and physical education and recreation and from the fields of speech and hearing, occupational therapy, physical therapy and group work should evaluate the need for special subject personnel and develop a program of training for attendants. Such a team should also work out space requirements to carry out these activities within the wards.

The 36 specialty consultants initially required by the four regional centers would cost approximately $250,000 annually, estimating an average salary of $7,000 per staff member. Annual costs may be greatly increased once staff requirements have been established.

"Homebound" instruction also offers an excellent opportunity for social interaction among residents. Every effort should be made to provide a suitable area for these activities within each building, so that residents may receive instruction in small groups.

CLASSES FOR EMOTIONALLY DISTURBED CHILDREN

Educational services should be made available to residents who are emotionally disturbed and may require individual instruction and a special approach. These children should be taught by persons experienced in working with the emotionally disturbed until the children are capable of participating in classes with other residents.

As educational services are generally expanded, the number of residents requiring special instruction because of emotional disturbance will become more readily apparent, permitting more accurate estimates of the number of teachers required.

Each teacher should be responsible for the instruction of five to 10 emotionally disturbed children, depending on the extent to which they require individual work or whether they can function in small groups. Approximately four teachers should be employed initially to work with emotionally disturbed children at each of the regional centers, at an approximate annual cost of $100,000 for the four regional centers. The number of staff persons needed to work in this area will probably exceed this initial estimate.

MAXIMUM USE OF NEARBY SCHOOL SYSTEMS

As many residents as feasible should attend classes in the public schools of neighboring communities. Such a policy supports the efforts of the regional centers to reintegrate as many residents as possible into the community. In addition to establishing a beneficial contact between residents and children residing in nearby communities, such arrangements enhance outside contacts and may have a positive effect on the attitudes of local persons.

At the present time, only about 10 residents from each regional center could attend the public schools of neighboring communities.

A number of school systems located near the regional centers are at present utilizing the educational facilities of the center for some of their special class students.

Reciprocal arrangements between regional centers and local communities for the education and vocational preparation of residents and local children are being successfully utilized in Connecticut. The possibility of formal reciprocal arrangements between the Department of Education and the Department of Mental Health in Massachusetts for providing educational and vocational services should be investigated.

The Commonwealth should reimburse local communities 100% for tuition expenses and 100% on a prorated basis for the cost of capital construction for special classes for retarded children through the School Building Assistance Commission of the Massachusetts Department of Education.

CLASSROOM NOMENCLATURE

Uniformity among the regional centers in classroom nomenclature which corresponds more closely to generally applied categories within the field of education is recommended. Present categories tend to give insufficient weight to social and physical development, mainly stressing intellectual levels.

Classroom nomenclature should be reclassified based on the following approximate chronological age divisions. Each regional center should retain flexibility in placement.

	Years
Nursery	3–7
Primary Educable	7–10
Primary Trainable	7–10
Intermediate Educable	10–13
Intermediate Trainable	10–13
Prevocational Educable	13–16
Prevocational Trainable	13–16
Vocational Educable	16–21
Vocational Trainable	16–21
Adult Education	21 or older

CLASSROOM COMPOSITION

As noted in the public school education section, limiting the maximum enrollment and the age range of residents in classes permits the greater individualization of instruction so necessary for children who often suffer from associated disorders.

Recommendations for classroom composition are intended to be flexible, recognizing that variations are necessary due to the quality of staff, the age of students and the nature of their handicaps.

LENGTH OF THE SCHOOL DAY

Nursery classes in regional centers should be in session a minimum of three hours per day. Curricula for all other students should be the length of a full school day.

The word "curricula" refers to vocational, social, recreational, as well as academic instruction, and stresses the concept that these services should be provided in an integrated manner and should receive priority in the program for the residents.

Exceptions may be made by the proposed Assistant Superintendent for Social Development, Education and Training for those children who may require a program of reduced length.

ENLARGED FACILITIES AND STAFF

Presently, the limited staff available at the regional centers makes the reduction of classroom size and the extension of the school day impossible. The educational and training staff should be supplemented by an estimated 25%–33% to accommodate students in smaller classes and to allow a longer school day. This represents an estimated increase of 40 to 50 teachers and vocational instructors to those presently on the staff of the regional centers and will cost approximately $250,000–$300,000 annually.

Additional staff recommended for "homebound" instruction, special subject instruction, adult education and classes for emotionally disturbed children are not covered by this recommendation.

Additional classrooms and school facilities will be required to implement the recommendations on classroom composition and size. However, old and inadequate existing school buildings should not be enlarged. New facilities may have to be constructed.

As a result of research and demonstration projects, school facilities and teaching personnel may undergo radical changes to meet the educational and training requirements of severely retarded residents. Plans for new construction should be sensitive to these developments.

ADULT EDUCATION

Many adult residents never had the opportunity to attend school when they were younger because they were not considered eligible under existing policies. Some of these adults are presently receiving instruction and are responding very well to academic and special subjects. An estimated 400 adults are presently participating in varied programs of instruction on a regular basis.

Adult education should be provided regularly for all residents above the age of 21, except for special cases. Instruction should consist of academic, vocational and social skills, commensurate with the residents' interests and level of abilities. Present estimates are that approximately 2,500 residents above the age of 21 would benefit from adult education. If each class enrolls about 20 adults and meets for a total of one school day per week, each instructor could assume responsibility for two classes plus 15 residents on the wards, a maximum of 55 residents. On that basis, between 45 and 50 instructors will be required to provide adult education services at an annual cost of between $270,000 and $300,000. Supervisory and administrative costs will increase beyond this amount.

Development of a full scale adult education program may require attention to a great variety of educational needs about which little is known as yet. Consideration should be given to expanding the program gradually with provision for evaluating curricula and teaching methods.

CURRICULUM

An increasing number of severely retarded residents now comprise the population of the regional centers and require educational services. This change in the population brings with it the need to reformulate educational goals, teaching methods and curriculum content. Special consideration must also be given to the multiply handicapped and the emotionally disturbed.

Staff participation on all levels is required to help determine the most appropriate curriculum content and the most effective methods for teaching academic, vocational and social skills. The proposed Assistant Superintendent for Social Development, Education and Training should convene and be responsible for the ongoing meeting of curriculum study groups at each of the regional centers.

To assist in this process, curriculum guidelines for the regional centers should be developed by appropriate staff within the Department of Mental Health and the Department of Education, working cooperatively with staff members from the regional centers.

SCHOOL PSYCHOLOGISTS

Certified school psychologists should be added to the educational staff of each regional center to participate in evaluating the child's academic, vocational and social progress, to help develop systematic procedures in the children's educational process and personality development and to participate in research related to the student's educational and psychological development.

School psychologists should also help teachers and administrators in working with students who have special learning problems or emotional problems.

SUBSTITUTE TEACHERS

Substitute teachers should be available to replace teachers who are absent because of illness or participation in professional conferences, individual evaluations and study groups.

At present, when a teacher is absent, classes are either combined or not held. As teachers are encouraged to assume an increasing amount of job related commitments, and as the size of the teaching staff grows due to the expansion of educational services, teacher absences will increase and additional classroom coverage should be available to provide classroom continuity.

It has been difficult to get qualified teachers to work on a part time basis as substitutes. With the expansion of the educational staff, substitute teachers could be employed on a full time basis.

One possibility is the employment of additional remedial specialists as full time members of the staff, who could assume responsibility for a class and work in the area of their specialty when a substitute teacher is needed. This plan would assure the utilization of these staff members at all times, regardless of variations in the requirements for substitute teachers. As full time members of the staff they would be familiar to residents and reduce the adjustment problems that residents might have with an unfamiliar teacher.

On the assumption that every person on the instructional staff will be absent 15 working days per year (five days due to illness and 10 days due to job related commitments), one substitute teacher or remedial specialist would be needed for every 15–20 members of the instructional staff. On the basis of recommended staff expansion, about 15 substitute teachers would be needed by the four regional centers at an approximate annual cost of $100,000.

SPECIAL SUBJECT TEACHERS

Instructions in subjects such as music, physical education, home economics, language, speech and reading, is presently carried out by persons employed in the institutional teacher pay block. Separate job categories should be created for special subject teachers and for therapists, as well as for other professionals who may be added to the staff in the future. Specific positions will provide appropriate recognition to the importance of these areas in the total education and training of residents. In addition it will make it possible to establish guidelines for the required number of persons needed in each specialty.

On the basis of recommended ratios, 120 special subject teachers and therapists are needed for the ambulatory residents presently enrolled in the schools. Twenty-eight special subject teachers are presently working in such capacities in regular teacher's pay blocks. An additional 92 special subject teachers and therapists are needed at an approximate annual cost of $600,000, assuming an average annual salary per instructor of $6,000 and the therapists of $6,500.

Estimates for special subject teachers and therapists are based on the present school enrollment (1,667) and do not cover the requirements for "homebound" instruction discussed earlier in this section.

VOCATIONAL TRAINING

Preparation of residents for work commensurate with their level of ability is a major goal of education at the regional centers. Some residents are being brought to a point where they are able to work outside the institution. Placements in the community are presently being utilized for selected residents for work training and evaluation by each of the regional centers. Others receive work training and fulfill an important function in helping to maintain the center with work in the shoe repair shop, the laundry, the barber shop, the farm, and as beauticians and seamstresses. There are some residents who cannot contribute in this manner, but who may profit from sheltered work assignments which have no maintenance function but are important for individual development.

As more severely retarded residents have taken on work assignments, many have shown an ability to perform duties of which they were not thought to be capable. However, they may need longer to learn and may work more slowly. This has necessitated the reformulation of previous production standards and the reorientation of vocational instructors. Of equal importance is the reorganization of the work experience program and the establishment of new and different work areas to meet the changing requirements of residents.

Because of the great variations in vocational potential and in capacity for change among residents, periodic evaluations should stress vocational aptitude when residents reach the age of 12. Specific job skills, work habits and social functioning are closely related to job performance and residents should participate in training programs and be assigned to work stations on the basis of individual requirements.

About 400 residents are presently participating in prevocational work study programs at the regional centers. About 2,500 residents are assigned to on-the-job training and to community work training and evaluation.

Coordination among top level education and training staff, teachers, vocational training personnel, matrons, rehabilitation counselors and other staff is extremely important. Interaction should be encouraged to provide an effective program of educational and vocational services. Staff members should be able to relate their specific skills to the training goals established for each resident.

Two rehabilitation counsellors were recently added to the staff of each of the regional centers to coordinate vocational services to the residents, to conduct counselling groups and to work with parents. Directors of education and training and supervisors in education have also been added to the staff of each regional center to strengthen coordination and support the expansion of educational and vocational programs.

A number of vocational programs are being developed at the regional centers. One is a subcontract workshop which will provide training facilities corresponding to local industry. Depending on the nature of the work, workshops may serve as a primary training area and as an alternative for a number of those residents who cannot be assigned to work stations. Consideration is presently being given to the establishment of workshops in three out of four regional centers.

Some residents at Wrentham are commuting to the workshops of Morgan Memorial. This program provides valuable experiences outside the regional center for residents who are not ready for placement in the community. Cooperative programs utilizing local area business and industry as vocational training and evaluation resources are presently being carried on by each of the regional centers. These and similar programs appear to be most promising. As they establish their usefulness, the programs should be expanded as a means of providing additional areas for placement.

JOB SPECIFICATIONS

With the creation of new positions, the hiring of additional staff and the administrative reorganization into functional units, staff responsibilities and assignments must be revised. Representatives of the unions, professional associations and the departments involved should participate in the review of the job specifications of all personnel at the regional centers with representatives from the Department of Mental Health. Appropriate changes should be recommended to the Division of Personnel and Standardization.

SALARIES AND INCREMENTS

An over-all review by the Department of Mental Health of salaries and ratings of personnel is recommended in the section on manpower and training. However, special attention should be given to equalizing benefits for teachers and other training personnel.

As is the case in public schools, specific salary increments should be granted to those teachers and training personnel who have completed graduate work. Credit should be given for experience of teachers in public or private schools in Massachusetts and in other states.

As increasing demands are made upon the skills of educators at the regional centers, salaries and working conditions must be competitive with those in surrounding communities.

QUALIFICATION OF TEACHERS

Teachers are receiving inservice training at regional centers through regular staff meetings, special courses and in some cases, by temporary assignment to projects being conducted by other departments at the center. Although these make an important contribution in raising the qualification of teachers, state certification in special education should be a requirement for all teachers.

The Department of Mental Health endorses teacher certification standards developed by the Department of Education. As of May, 1966, only 30 of 73 teachers in the state residential schools were state certified, although a number were taking courses related to their work. As new job classifications are established, present educational requirements set by the Division of Personnel and Standardization should be raised to meet the certification requirements of the Department of Education.

Teachers require an extensive background in special education because of the changing needs of residents, the innovations taking place in teaching techniques and the reformulation of curricula.

ROLE OF STATE DEPARTMENT OF EDUCATION

The State Department of Education, through the Bureau of Special Education, should assume a more active role in providing consultation in areas such as curriculum development and resource information on texts and training aids.

About 4,500 children and adults require educational services at the regional centers. This not only includes persons who are attending classes but also those requiring "homebound" instruction.

In view of the large number of students involved and the changes being undertaken in educational methods and curriculum, one person on the level of senior supervisor in education from the Department of Education should be assigned to each of the regional centers, to consult with staff and to provide resource information. Supervisors may also act in a liaison capacity between the regional center, the Department of Education and the superintendents of local schools in neighboring communities where residents are attending classes. The addition of consultative staff from the Department of Education may also facilitate affiliations with teacher colleges for the training and placement of student teachers.

Four senior supervisors in special education are needed, at an approximate total annual cost of $40,000.

Senior supervisors in education should work in a staff, not line capacity, to prevent dual responsibility and other administrative conflicts. The elevation of directors of education and training to Assistant Superintendents of Social Development, Education and Training will facilitate administrative relations between them and the Senior Supervisors of Education. The position of coordinator of education and vocational training services at the central office of the Department of Mental Health should be established and the classification raised commensurately with that of educational and training staff at the regional centers so existing supervisory relationships may be maintained.

Special class standards set forth by the Department of Education should be followed by the Department of Mental Health.

The Department of Education should act as the certifying agent for new teachers. Specifications for the position of institution school teacher should be rewritten to bring requirements in line with those of the Department of Education.

EXPANDING VOCATIONAL TRAINING AND EMPLOYMENT

RECOMMENDATIONS

FINANCING OF PROGRAMS

115. Massachusetts Rehabilitation Commission should assume a major role in providing or securing vocational rehabilitation services for the retarded. To accomplish these goals, matching funds should be appropriated by the legislature to fully utilize federal funds authorized under the Vocational Rehabilitation Act Amendments of 1965.

116. Services of proven effectiveness in vocational rehabilitation which were initiated through federal funding, but for which federal funding is no longer available, should be continued and expanded. The legislature should approve budgetary requests of departments for these purposes.

COLLABORATION AMONG DEPARTMENTS

117. Existing collaborative activities between the Massachusetts Rehabilitation Commission, the Department of Education, the Division of Labor and Industries, the Department of Correction, the Division of Youth Service and the Department of Mental Health should be strengthened to better coordinate vocational services at the local level.

118. The Massachusetts Rehabilitation Commission, the Division of Employment Security, the Department of Education and the Department of Correction, the Division of Youth Service, and the Department of Mental Health should cooperate with the proposed Office of Retardation to conduct a study of their existing vocational services for the retarded to determine the extent of services presently being provided and the role which should be assumed by each to work most effectively with other agencies in the provision of training, restorative, counselling and placement services.

RESEARCH AND DEMONSTRATIONS

119. Agencies providing vocational services should conduct demonstrations and research to evaluate the results of existing services and to develop more effective methods for preparing retardates for employment.

Additional funds should be made available to carry out such demonstrations.

120. Training workshops should be restructured and employment programs and curricula developed on the basis of demonstration research being conducted by the Massachusetts Rehabilitation Commission, the Mental Retardation Planning Project's Post School Adjustment Study, the Department of Education and the Department of Mental Health.

Results of such studies should be made available to all interested agencies and departments through the Office of Retardation.

WORKSHOP SERVICES

121. The Office of Retardation should stimulate demonstrations and studies of extended employment workshops to help evaluate in what ways workshops can be utilized for those retarded who cannot function in competitive employment.

122. The Office of Retardation should stimulate collaborative efforts among the Departments of Mental Health, Public Welfare and relevant voluntary agencies to assure workshop clients supportive services such as foster care, group homes, social clubs and recreational and counselling services.

TRAINING OF PERSONNEL

123. Emphasis should be given to the training of professionals in vocational rehabilitation of retarded persons, through the strengthening of curriculum content in this area and through joint courses and programming between departments of special education and rehabilitation.

124. Specialists in vocational rehabilitation of the retarded should be on the staff of each state health, education, and welfare agency to provide consultation and assistance to agency staff and to other organizations conducting vocational programs.

CIVIL SERVICE POSITIONS

125. The Massachusetts Rehabilitation Commission and the Civil Service Commission should introduce legislation to permit the employment of qualified retarded persons in state civil service positions.

RESOURCE DIRECTORY

126. A directory of all available vocational rehabilitation resources for the retarded in the Commonwealth should be compiled by the Office of Retardation and updated annually.

PREFACE

A two year comprehensive vocational rehabilitation planning project is already underway in Massachusetts.

Recommendations in this section should be implemented without awaiting that plan. The new planning project provides an excellent opportunity for relating this report to the over-all rehabilitation picture and for exploring additional areas. This is particularly important in rehabilitation since the retarded are only one of a number of disability groups being served by rehabilitation agencies.

The development of rehabilitation services affecting all disability groups should be based upon the findings of the comprehensive vocational rehabilitation planning project.

THE IMPORTANCE OF SOCIAL SKILLS

This section focuses on ultimate goals. The process which must precede employment includes not only the teaching of vocational skills but adequate preparation in all facets of social living. This provides the underpinning for the retarded person's ultimate success in competitive or in sheltered employment. Therefore, it is necessary that self care and social living skills comprise a basic component of all vocational training programs.

THE NEED TO BE PRODUCTIVE

One of the most valued assets of our society is the capacity of every individual to be productive at some level. With sufficient and appropriate training, even severely retarded persons may be able to fulfill a variety of vocational roles. Such potential is most significant and justifies the mobilization of all necessary services. Whether we prepare the retarded for gainful employment, for partial self support under sheltered conditions, or for marginal productivity in supportive surroundings, work enhances the individual's dignity and self esteem, so important to the person's over-all well being.

Vocational services needed by retarded persons vary with the extent of their disability. Adequate preparation in social, vocational and academic skills is necessary for all. Others require additional preparation, careful job placement and follow up and in some cases, extended sheltered employment.

Vocational preparation for special class students is being increased throughout most of the schools in the state and in the regional centers. Educable retarded children around the age of 13 to 16 are receiving prevocational training including job information, and needed work habits and social skills. This training is continued between the ages of 16 to 18 with additional classes in budgeting, the use of public transportation and the assignment to part time work experiences. Between the ages of 18 and 21, as many students as possible are placed in competitive employment in business and industry or receive additional training in sheltered workshops. Education at this time focuses on activities of daily living and helps students to cope with community adjustment.

With trainable students the curriculum emphasizes self care skills, communication and social functioning. Vocational skills are generally geared to more closely supervised and sheltered working situations.

Closer working relations are being undertaken between the major departments involved in vocational preparation and rehabilitation such as the Department of Education, the Massachusetts Rehabilitation Commission, the Division of Employment Security, and the Department of Mental Health. These ties are helping to provide a smoother transition for special class students seeking employment, for those who may need additional training prior to job placements, and for residents who are returning to the community. Such collaboration should be utilized as fully as possible to clarify the roles and major responsibilities of each department and to provide a greater continuity of vocational services, particularly for persons requiring extended sheltered employment, retraining, or repeated job placements.

The following areas should also receive priority:

- Development of a fixed point of referral for specialized and related vocational services which would be available on a continuing basis. This responsibility could be assumed by the mental health-retardation centers.
- Full utilization of existing workshops and the development of extended employment workshops. Where possible, extended employment should be a component of multipurpose sheltered workshops.
- Demonstration — research projects to extend knowledge regarding the vocational capabilities of the retarded and to increase the effectiveness of training methods and materials.

EXPANDED SERVICES IN THE SCHOOLS

Recent legislation (Chapter 72, Acts of 1966) required every town and school district to establish an occupational training program for retarded children under 18 years of age and permitted the establishment of programs for persons beyond that age. This should lead to the extension of work-study programs and to the provision of actual job experiences.

Until now, schools have not given sufficient attention to the development of vocational skills. A greater effort should be made to integrate prevocational subjects into the curriculum and to relate the school curriculum to the ultimate vocational demands which will be placed upon special class students. The inclusion of classes for personal adjustment, the use of community facilities, the development of basic work skills and preparation for the adult role are all significant in preparing students for work.

Programs of collaboration between local schools and the Massachusetts Rehabilitation Commission, such as the current project in Brockton, should be expanded. Vocational counselors from the Massachusetts Rehabilitation Commission should be available to work closely with local schools to help prepare and to place special class students. Counselors may require inservice training in working with retarded students to help them carry out this responsibility most effectively.

With the majority of special class students presently terminating school at the age of 16, the extension of occupational training programs is a challenge to the development of a functional curriculum which will motivate students to participate. Special consideration must be given to an appropriate occupational training program for students from trainable special classes who are included in this legislation.

The Boston school system presently provides occupational training for 80 boys at the David L. Barrett School. Such programs are extremely valuable and should be expanded to accommodate more students and to develop a program for girls as well as for boys, and to benefit students with I.Q. scores below 70.

Job information, vocational training and evaluation, and work experience programs are being offered at each of the regional residential centers. These services have been recently expanded with the employment of two full time rehabilitation counselors at each of the regional centers to work in the area of vocational training, evaluation and habilitation.

RESEARCH AND DEMONSTRATIONS

Ongoing evaluation of existing vocational services and the search for more effective methods for preparing retardates for employment are equally as important as the expansion of services and the hiring of additional personnel. Demonstrations are urgently needed to provide information in the areas of motivation, functional curricula and the teaching of social skills, activities of daily living, and community adjustment which might result in a model for more effective training methods. Information is also needed about employer attitudes and about the evaluation of work ability and job adjustment.

POST SCHOOL ADJUSTMENT STUDY

Little is known about how services for special class students can best be related to their adjustment as adults. A variety of service models must be utilized and their effectiveness carefully evaluated.

The Post School Adjustment Study, sponsored by the Massachusetts Mental Retardation Planning Project and funded by the Office of Economic Opportunity is conducting a statewide study of the roles and utilization of existing service models in the vocational adjustment of educable retarded boys who terminated from special classes throughout Massachusetts during the calendar years of 1961 and 1962.

This study is seen as the first stage of a two part research and demonstration program aimed at developing and strengthening the network of specific programs and services for a sizeable "population at risk" in today's job market — those young men considered to be handicapped because of their limited intellectual capacity.

The educable retarded comprise the largest portion, by far, of those designated as retarded. Some estimates run as high as 90%. However, up-to-date facts about this group are comparatively sparse and incomplete. Consequently, a study of the vocational adjustment of special class students should be an aid to current long range planning for the retarded. Information being sought from the boys and their families in the present study include: How well prepared are the boys for work, in both social skills and vocational training? Where do they go for help in finding jobs? What kinds of jobs do they get? What help do they need in making a vocational adjustment; when, and from whom? What help are they actually getting, particularly from those organizations and agencies with programs and services for which the retarded boy and his family might be eligible?

Several previous studies of the educable retarded indicate that the major proportion of this group come from personal and social backgrounds characterized by a high degree of emotional, social and cultural deprivation. These findings have raised the question as to whether many, if not most, of the educable retarded suffer primarily from other than physiological defects or conditions. Consequently, the study is attempting to ascertain what factors in the boy's background and preparation for work appear to be related to his post school vocational adjustment. Included in these are the patterns of utilization, by the boy and his family, of agencies and services in the community with programs to assist the retarded.

DIVISION OF EMPLOYMENT SECURITY

The Division of Employment Security is responsible for the supervision and operation of 44 free public employment offices throughout the Commonwealth. These offices provide employment counselling and job placement services for unemployed persons in the Commonwealth and serve the retarded through their program of "Services to the Handicapped" which includes counselling, testing, job development and selective placement. Each local office has at least one person designated to provide services to the retarded and other handicapped individuals. At the state level, the Special Applicant Services Department of the Division of Employment Security includes the Handicapped Division which provides technical assistance to local offices on matters pertaining to "Services to the Handicapped." This Division has responsibility for providing staff assistance in the development of new programs and evaluation of the existing programs of local offices.

Although the state level administrative office issues directives to the local offices pertaining to services and programs, the highly decentralized system makes it difficult to achieve uniformity of services. There is no hard data concerning the operations of the Division of Employment Security and the local offices as they relate to the retarded.

No specific procedures for identifying retarded applicants exists within the Division of Employment Security unless the individual has been previously identified or referred directly from a special class, the Massachusetts Rehabilitation Commission, or other specialized facility. Some former special class students are identified on the basis of their schools, as indicated in their personal histories.

It is the task of the counselor to assign a job classification to the applicant taking into account the applicant's education, training, and job attitude. If there is difficulty in classification, the applicant is referred to a counselor to test his general aptitude, manual dexterity, and other occupational characteristics. Upon job classification, the employment counselor attempts to place the applicant by matching his abilities with available job specifications. In the past, retardates have been placed in positions as dishwashers, kitchen helpers, clerical workers, and textile and garment industry laborers.

At the present time the degree of success the Division has achieved in its efforts with the retarded is not known. There is no follow up after placement and the applicant is on his own once he begins work.

Selected facilities of the Department of Mental Health have received aid from the Division in administering tests in the area of vocational interest and aptitude. Availability of these testing services should be greatly expanded.

The Division has a cooperative agreement with the Massachusetts Rehabilitation Commission, mandated by Chapter 6, Section 81 of the General Laws. It covers liaison responsibility, occupational testing, exchange of information, development of public understanding and employer relations. The agreement clearly defines the role, and functions of each agency, and should be fully implemented as an excellent mechanism for interdepartmental coordination.

Informal cooperative arrangements also exist with the Department of Education, the Department of Mental Health, local school boards and private organizations in securing employment opportunities for the retarded. Such cooperation has proven to be helpful and should be provided on a regular, more intensive basis.

MASSACHUSETTS REHABILITATION COMMISSION

The Massachusetts Rehabilitation Commission has the responsibility for rehabilitating persons with physical, mental, and emotional disabilities.

To be eligible for the services of the Commission, a client must have a "mental, physical or emotional disability which is a substantial employment handicap, but who may be expected to be either prepared for remunerative employment or as a housewife or a homemaker within a reasonable amount of time."

The retarded often require and may benefit from rehabilitation services. They comprised approximately 10% of the total number of persons referred to the Commission in fiscal 1964. Of the 724 retardates referred to the Commission, 38% were accepted for rehabilitation services, 36% were not accepted and 26% remained on a referred status as of April 1965. A total of 215 of the 275 retarded persons accepted for rehabilitation services were classified as rehabilitated in the year 1964.

The increasing number of retarded persons being served by the Commission and the multiple problems which must often be resolved to prepare them for employment may necessitate specialist counselors for the retarded. There is now a trend towards specialization with counselors stationed full time and part time at mental hospitals and general hospitals for case finding and the provision of services.

Problems must still be resolved of integrating these counselors as members of the professional team and in helping other professionals to utilize the skills of vocational counselors.

Specialist counselors should be considered by the Commission to work on a full time basis with handicapped adolescents at public and private schools and at regional centers, including the retarded, physically handicapped and the emotionally disturbed. The research and program planning unit of the Massachusetts Rehabilitation Commission should determine the number of counselors to be added to the staff of the Commission to provide these services.

Careful consideration should be given to the addition of rehabilitation counselors to the staff of each district office who are more thoroughly trained in vocational rehabilitation of the retarded, and to teach these skills as an important aspect of inservice training.

Planning and supervision of rehabilitation programs for the retarded may also require specialized attention on a high administrative level. The feasibility of an assistant commissioner of the Massachusetts Rehabilitation Commission for retardation services should be explored.

UTILIZATION OF FEDERAL FUNDS

With the recent passage of the Vocational Rehabilitation Amendments by Congress, the Massachusetts Rehabilitation Commission has been thrust into a major role with respect to vocational services for the retarded. Substantially larger appropriations are being made available at the federal level for the expansion of staff and services for the disabled in Massachusetts. In addition, substantial sums are available to public and private agencies for the expansion of facilities and workshops through new granting procedures. Special attention is being given to the needs of retarded clients by extending the evaluation period to 18 months, when necessary. Emphasis is placed on the development of different models of sheltered workshops in conjunction with residential units.

The allotment of federal funds to Massachusetts under the new law will be $5,423,603 for fiscal 1966; $6,327,537 for fiscal 1967; and $7,231,471 for fiscal 1968. In fiscal 1964 the total budget of the Commission was $2,479,519, consisting of $1,477,332 federal funds and $1,002,187 state funds. Massachusetts will have its funds matched at a rate of three federal dollars for each state dollar available for fiscal years 1967 and 1968 up to the state's allotment. It is estimated that during the years 1962–1965, Massachusetts forfeited $1,773,000 in federal matching funds. To utilize the federal funds available state matching funds of $2,109,179 for fiscal 1967 and $2,410,490 for fiscal 1968 will have to be appropriated by the legislature for the state to earn its federal allotment.

The 1965 Amendments also provide for statewide planning in vocational rehabilitation with $100,000 annually available to Massachusetts over a two year period beginning October 1966. Federal grants will cover 100% of the cost.

Statewide planning activities are designed to accomplish three general objectives:

- To bring into being a well defined picture of state resources for rehabilitating the disabled and a clear picture of foreseeable needs.
- To help assure orderly growth and development and a minimum of duplication.
- To arrive at an organized statewide plan by which all disabled persons needing rehabilitation services can receive them by the year 1975.

SURVEY OF FACILITIES AND WORKSHOPS

In addition to these funds, the federal government made $37,000 available to the Massachusetts Rehabilitation Commission on a 10% matching basis for each of the next four years to conduct a survey of facilities and workshops in the Commonwealth. This survey will obtain information on the type and extent of services available to the retarded and the degree to which present facilities are being utilized. Staff will include a director, a research director and three field specialists who will also be responsible for helping communities to develop workshop services. The survey staff will work closely with the Vocational Rehabilitation Planning Commission.

RELATIONS AMONG SCHOOLS, MASSACHUSETTS REHABILITATION COMMISSION AND THE DIVISION OF EMPLOYMENT SECURITY

Close collaboration between the local schools and the staff of the Massachusetts Rehabilitation Commission is necessary to improve the preparation of special class students for employment. Vocational rehabilitation counselors and occupational specialists should work together to promote effective expansion of work stations and occupational training programs. Combined work study programs, such as are presently being conducted collaboratively in Brockton, should be expanded to other communities. Consideration should also be given to offering training courses in the school conducted by the garment, laundry, restaurant and other industries.

Prior to termination from school, the rehabilitation counselor should be involved in the evaluation of a student's readiness for employment and provide the student additional training and/or a sheltered job placement when necessary. Immediate and effective service is most important so that students initially seeking employment will not be unnecessarily discouraged. Ongoing working relations between the schools and the Commission would help to inform rehabilitation counselors about students. Services could also be improved by speeding up the present referral system between the local schools and the Commission. Current referral procedures are complicated and pass through a number of agencies before reaching a district rehabilitation office.

Service to students may be speeded up if students were referred directly by their schools to the district office of the Massachusetts Rehabilitation Commission. Most counselor case loads are considerable and may have to be lowered in order to work with all the cases being referred.

A comprehensive program of vocational services is being provided by the regional centers and the North Reading Rehabilitation Center. The relationship of facilities of the Department of Mental Health with the Massachusetts Rehabilitation Commission and the Division of Employment Security is extremely important to the placement and work adjustment of many individuals who are presently institutionalized. Efforts should be made to strengthen the relations among these agencies.

RELATIONS BETWEEN THE MASSACHUSETTS REHABILITATION COMMISSION AND THE MENTAL HEALTH-RETARDATION CENTERS

As mental health-retardation centers are developed in the 37 areas throughout Massachusetts, they will assume the responsibility of serving as fixed points of referral for retarded

persons and their families. Since the Commission is expected to assume a major role in providing vocational services, a rehabilitation counselor should be placed by the Commission at each of the centers to work with clients and to insure a close working relation between the centers and the district offices. As new centers are planned, office space should be provided for the vocational rehabilitation counselor.

Schools will continue to play an important role in referring mildly retarded students for post school vocational services because it will be some time before every area in the state will have a mental health-retardation center and it is not yet clear to what extent these will be used by mildly retarded persons.

RELATIONS BETWEEN REGIONAL RESIDENTIAL CENTERS FOR THE RETARDED* AND THE MASSACHUSETTS REHABILITATION COMMISSION

Full collaboration between the staffs of the regional centers and the district offices of the Massachusetts Rehabilitation Commission would be a valuable asset in the placement of residents in employment and in providing guidance to certain aspects of the training program. Communication between the two rehabilitation counselors who have recently been added to the staff of each of the regional centers and the counselors of the Massachusetts Rehabilitation Commission has not yet been adequately established. Cooperative procedures should be fully explored by the Vocational Rehabilitation Planning Commission.

Establishment of pilot projects by the Massachusetts Rehabilitation Commission at the regional centers similar to those presently being conducted in collaboration with some local school systems should be explored.

A further means of collaboration would be the use of regional centers to provide selected training for counselors and to offer trainees direct experience in working with retarded persons.

EMPLOYMENT RESOURCES

Information about employment resources for retarded persons in restaurants, laundries, nursing homes, in maintenance positions and other areas is not presently available and would be most useful to the staff of all departments dealing with the retarded. For example, there is no hard data on farm work, with considerable disagreement, at this time, as to whether it is a suitable source of employment for retarded persons. It would be valuable if publications could be made available which would indicate the job objectives for retarded persons in various types of employment, such as is available for the hospital industry in a publication of the Massachusetts Rehabilitation Commission. Updated information based on surveys of job opportunities around the state, such as farming, crop picking, and in industry, would also be extremely helpful.

SHELTERED WORKSHOP FACILITIES

The need for workshop services should receive priority consideration. As of April, 1965 there were 19 certified workshops in Massachusetts. Workshop programs and the extent of professional services available vary. Services may include diagnosis and evaluation of work potential, training in vocational and in related skills, job placement and follow up and supportive services such as group counselling, work with parents and recreational activities.

Approximately 730 retarded persons received services in programs under voluntary auspices during 1965. These agencies include those of associations for retarded children, New England Rehabilitation and Work Center, Morgan Memorial Goodwill Industries, Jewish Vocational Service and the Community Workshops.

The North Reading Rehabilitation Center was opened by the Department of Mental Health in 1963 for retarded youths who may be trained on a day or residential basis. Fifty beds are available for clients who live beyond commuting distance. Present enrollment consists of 180 persons between the ages of 16–26. Work placements have been found for 114, whose progress is being closely followed.

Social development, psychological development, and medical care where needed, are utilized as the basis for bringing about vocational functioning in competitive employment. Clients work as apprentices, learning vocational skills on the job. Academic subjects are taught as they specifically relate to job requirements.

Occupational training centers are also operating in conjunction with the Worcester and South Shore mental health centers. Services are also purchased by the Massachusetts Rehabilitation Commission from workshops conducted by the local associations for retarded children and Goodwill Industries.

Considerable expansion of workshop services may be anticipated with the extension of evaluation time up to 18 months, and the eligibility of more severely retarded persons for long term evaluation. This appears to be true despite the fact that at present some workshops are not fully utilized. Whether an adequate amount of workshop services can continue to be purchased by the Commission, or whether it may become necessary for the Commission or another public agency to provide direct workshop services needs careful exploration during the Survey on Facilities and Workshops.

Two regional public school sheltered workshops are being planned for the Cambridge, Somerville and Medford area, and for Framingham and 11 surrounding communities, under the auspices of local school districts. The effectiveness of these programs should be closely evaluated as they might serve as a new source for expanded workshop services. If this comes about, the Massachusetts Rehabilitation Commission might explore the feasibility of also purchasing workshop services from local school districts.

EXTENDED EMPLOYMENT

A major thrust in sheltered workshop services has been on behalf of those who are potentially employable. The present statutory definition of workshop (General Laws, Chapter 6, Section 77) does not encompass the concept of extended employment, a service which provides life long sheltered employment for those retarded persons who are only marginally productive and require close supervision.

The Massachusetts Rehabilitation Commission utilizes sheltered workshops for the purpose of evaluation and work conditioning or for interim employment while waiting for permanent placement. Even under the forthcoming expansion of workshop services under the 1965 Vocational Rehabilitation Amendments, very little is contemplated in the area of extended employment. At this time some extended employment is available at Morgan Memorial and as part of the comprehensive program for the retarded at the Worcester Area Comprehensive Care Center for the Mentally Retarded.

Extended employment workshops should be considered as an important part of the constellation of community services which must be available to provide alternatives to residential care. The greatest problem with extended employment

*Presently state residential schools.

workshops is their great cost. There is little or no client turnover and demands for service are likely to increase. Reliable figures as to the number of persons requiring extended employment are not available and a survey determining the need should receive priority.

It is generally agreed that extended employment workshops should form a component of multipurpose workshops for clients with a wide range of abilities, including those with potential for eventual employment as well as those who may be more severely retarded or disabled. It is felt that this arrangement enhances the learning environment and makes it possible to support improved functioning through new assignments within the workshop without affecting established relations and a familiar environment.

Functions of extended employment workshops should differ from that of day care centers. Retarded persons who cannot perform minimal realistic work on a day to day basis may be better suited to day care services. Work may not be meaningful to them. They may also be prone to a number of associated problems, so that keeping them at work would greatly increase staff costs.

SUPPORTING WORKSHOP SERVICES

A major obstacle to work adjustment for many retarded persons is not a lack of vocational skills, but the inability to relate to fellow workers and to play an appropriate role. These shortcomings in social functioning also affect their ability to utilize leisure time and to undertake certain aspects of self care without supervision. Supportive services to deal with these problems must comprise an integral part of expanded workshop programs. Arrangements such as foster care, group homes and halfway houses may be utilized to provide the needed supervision outside of working hours by providing leisure time activities in a familiar and secure setting. The proposed Office of Retardation should stimulate the Department of Mental Health, the Department of Public Welfare and relevant voluntary agencies to establish the appropriate supportive service in conjunction with workshop services.

Provision of these additional services will require increased legislative appropriations for the departments involved.

HOMEBOUND PROGRAMS

Persons whose physical or mental condition prevents them from leaving their homes to secure employment, education, training or rehabilitation services, should receive a complete application process in their homes to assess their rehabilitation, physical, psychosocial, recreational, and financial needs. In addition, these severely handicapped persons should receive special services such as home visitation, therapeutic and remunerative work, instruction, supervision, personal adjustment, medical, clinical, restorative, nursing, recreational, and personal and family counselling services as needed and available.

Homebound programs should comply with all state and federal laws and regulations applicable to homebound persons and to the principles developed by the Advisory Committee on Sheltered Workshops of the United States Department of Labor.

VOCATIONAL SERVICES FOR RETARDED PERSONS IN CORRECTIONAL AGENCIES

Retarded persons comprise a significant proportion of those confined in correctional agencies in Massachusetts. There are 143 defective delinquents at Bridgewater. An additional 47 of the 1,473 persons in the prison department and at the state hospital at Bridgewater, have also been identified as retarded. Of the 244 women sentenced to six months or more to the Framingham Reformatory for Women in 1965, 48 (16%), were identified as retarded.

Three types of vocational services are needed by the inmates of correctional institutions, including those in the county jails. All of these appear to be of particular importance to the retarded persons in the prison population. These services include: instruction in vocational skills, sheltered workshops and vocational counselling.

Sheltered workshop services are particularly needed for the defective delinquents and for the 637 mentally ill.

Instruction in vocational skills would be of benefit to the majority of prisoners, helping them to learn skills which they may utilize after their release as well as within the industrial maintenance program of the institution. Such instruction might be of great value to retarded inmates, who need additional time and help to master certain skills.

Inclusion of instruction as a component of the industrial maintenance program at correctional agencies would entail a reorientation of staff in respect to goals and production standards and an increase in instructional personnel.

Pilot projects emphasizing vocational instruction should be undertaken at selected correctional agencies to help determine program content and staff requirements.

Vocational counselling of inmates prior to their release has been valuable in their community adjustment. A pilot project is underway at Walpole State Prison. A counselor from the Brockton district office of the Massachusetts Rehabilitation Commission works one day a month counselling selected prisoners during the year prior to their release. Such services should be expanded to other correctional agencies and integrated with the program of instruction in vocational skills.

Vocational counselling prior to release may be particularly needed by adolescents under the jurisdiction of the Youth Service Board. Retarded prisoners may require some of the services which the Massachusetts Rehabilitation Commission can provide for them in making a work adjustment following their release.

EMPLOYMENT

A major concern in the placement of retarded persons in employment is that the label of retardation often carries with it a "limited function" stereotype. This may be particularly so when dealing with large firms where personnel directors, rather than individual proprietors, interpret employment policies.

Employers seek productive workers who are not disruptive, can follow orders and get along with fellow employees. Vocational training aims to develop this type of worker. Convincing employers that many retarded workers fulfill these requirements is still a distant goal. Carefully planned programs of public education in the area of employment may help in changing the attitudes of employers.

CIVIL SERVICE POSITIONS

The Massachusetts Rehabilitation Commission has actively cooperated with the U. S. Civil Service Commission in the placement of retarded persons in federal positions. More than 30 persons were placed during 1966 in positions such as mail handlers, custodial workers, and in unskilled clerical positions.

House Bill 3223 (1966) providing for an investigation and study by a special commission of the placement of vocationally trained retarded persons in the state civil service was recently defeated in the state Senate. However, similar programs at

the federal and state level have proven successful. A total of 1,676 retarded persons have been employed in civil service positions by the federal government. New York State's Interdepartmental Health and Hospital Council recently developed a program in conjunction with other state agencies to employ retardates in the state civil service.

To support future legislative action, the Massachusetts Rehabilitation Commission should initiate a pilot project to demonstrate the ability of retarded persons to perform selected work functions in the Massachusetts civil service system. Legislation should be submitted which will permit the employment of retarded persons in the state civil service.

SECURING ESSENTIAL MANPOWER

RECOMMENDATIONS

MEETING PERSONNEL NEEDS

127. The Legislative Commission on Mental Retardation in collaboration with the Office of Retardation and officials of state health, education and welfare agencies should undertake a study of grade and salary classifications and job descriptions of personnel working with retarded persons in all agencies of the Commonwealth.

NEW POSITIONS IN THE DEPARTMENT OF MENTAL HEALTH AND REGIONAL CENTERS

128. New positions recommended in this report for residential and educational programs should be implemented as soon as possible.

129. Positions of Director of Physical Therapy Services, Director of Educational Services, and Director of Vocational Services should be established in the central office of the Department of Mental Health.

INSERVICE TRAINING

130. Integrated and joint inservice training programs should be conducted on all staff levels. These should be viewed as an ongoing process for upgrading all personnel to provide them with current knowledge in their own, and in related fields, and to foster a better understanding of staff members' skills and improve collaboration among staff.

131. The Office of Retardation should assume responsibility for stimulating training of all state personnel working in programs affecting retarded persons.

PROGRAM DEVELOPMENT AND RECRUITMENT

132. Available federal grants should be used for traineeships to recruit college graduates, older married women and women with families, who might work part time. Persons from low income groups, should also be hired when they qualify, for a variety of positions from direct care to building supervisors.

Part time employment should also be encouraged by the provision of flexible working schedules which encourage persons to apply for positions they might not otherwise consider.

133. Department heads and other supervisory personnel in professions such as psychology, occupational therapy, social work, education, and nursing should be required to possess the advanced degrees necessary for them to qualify as field instructors in their respective professions.

134. Information about the responsibilities, opportunities, salaries, and training requirements for work with mentally retarded persons in various professions, should be made known to high school, undergraduate, and graduate students as well as to teachers and guidance counselors.

135. The staff of the Office of Retardation should work with the Board of Education and Board of Higher Education to prepare material in the field of retardation for curricula of professional schools, and on a more general level as part of the curriculum of high school and college courses.

136. Young persons should have direct contact with the retarded through such experiences as visits, part time small group leadership, summer employment and internships at regional residential centers and other facilities for the retarded. Funds for such programs should be provided in the respective budgets of these facilities.

VOLUNTEERS

137. New and imaginative roles for volunteers should be developed at the regional residential centers, particularly in providing leadership with small groups which foster social development.

BROADENING THE TRAINING

138. The development of interdisciplinary training and research centers which teach skills particularly applicable to the field of retardation should be supported by the Board of Higher Education. Financial methods should be developed through which state funds may be expended to establish and enlarge training programs in mental retardation at state and private colleges.

139. A portion of the allocation of not less than 2½% of the budget of the Department of Mental Health for training activities recommended by the Mental Health Planning Project, should be used to pay for training activities in retardation, by conducting needed courses, providing student fellowships and by supporting inservice training activities at individual facilities with special staff and equipment.

GRADUATE FELLOWSHIPS

140. Through the proposed training budget, all departments working with the retarded should initiate a program to support students training in professions related to retardation through fellowships and to provide funds for additional training of faculty.

141. Graduate fellowship support should be increased at the state colleges to professional students planning to enter the field of retardation.

PERSONNEL FROM JUNIOR AND COMMUNITY COLLEGES

142. The potential role of the junior and community colleges in providing personnel to work with retarded persons in direct care and as assistants to professionals, should be fully explored by the Office of Retardation in collaboration with the schools.

EVALUATION AND MODIFICATION OF TRAINING PROGRAMS

143. Closer working relationships should be developed among facilities working with retarded persons and state and private colleges and universities. Joint staff appointments should be developed.

144. Current training programs at colleges and universities should be reexamined on the basis of evaluative research to determine whether such training programs are appropriate for developing the skills needed to support new goals in the field of retardation, especially in such areas as self care and independent living.

FLEXIBILITY IN ADMINISTRATION

145. Educational requirements for professional positions governed by Civil Service should be required by Civil Service.

Procedures should be initiated by all Departments to work towards the repeal of Chapter 31, Section 6a, of the Civil Service Law to achieve this end.

UNASSEMBLED EXAMINATIONS

146. The appointment of professionals to positions should be based on their qualifications (unassembled examinations) rather than on the basis of a special examination for each position.

TEMPORARY CERTIFICATES

147. The Office of Retardation should conduct a one year study of the adequacy of temporary certificates for physicians, teachers and others.

PROMPT PAYMENT

148. All persons should be paid following the completion of their first work period, pending the completion of processing their applications.

AUTHORITY TO HIRE

149. Superintendents of state residential schools should have authority to hire appropriate personnel immediately to fill all existing vacancies, pending final approval by the Bureau of Personnel.

CIVIL SERVICE REGULATIONS

150. More frequent Civil Service examinations for various staff positions should be scheduled and the process of releasing examination grades speeded up, so that desirable staff members may be given permanent status sooner than is presently the case.

151. Massachusetts should follow the federal system for veteran's preference which provides disabled veterans with a 10 point preference over their attained grade and veterans without disability with a 5 point preference over their attained grade in competitive Civil Service examinations.

EXPANDING MANPOWER REQUIREMENTS

Relatively recent and rapid developments in the field of retardation are resulting in a significant expansion of services to retarded persons. Innovations in methods and techniques in education, changes in training and residential care, and increased efforts to achieve liaison and coordination all aim to make needed services more accessible to retarded persons and their families.

The manpower problem in the field of retardation is critical. Perennial staff shortages which affect state departments of health and welfare, as well as private agencies, and recent innovations, are bringing about changing requirements in the preparation of professional staff. Staff roles, staff functions, and new responsibilities for relating previously self contained areas of work to the work of other professions need to be reexamined.

As state residential programs of the Department of Mental Health are incorporated in local area programs, an increasing number of people will be needed to staff these new comprehensive programs.

A vast array of human disorders are massed together under the heading of retardation. It is hard to conceive of them as being served by a single specialty for which one profession could have anything like total competence. Some retarded persons present problems that are primarily medical, others primarily psychological, educational, or rehabilitative. Although there is professional expertise in each one of these areas, there is no one professional discipline that could encompass the skills necessary in all these areas.

Care of the retarded in residential centers was initially the responsibility of the medical and nursing professions. The additions of professions such as social work, psychology, and more recently, vocational counseling are relatively recent developments. Resulting shifts in responsibilities and overlapping professional functions are still in the process of being resolved. Because professional roles are still being defined and developed, students preparing for the professions are generally unaware of the many career possibilities in the field of retardation.

Insufficient attention is being devoted to retardation in the curricula of colleges and high schools directed at dispelling still common notions of fear and hopelessness regarding work with the retarded. In addition, working conditions in many facilities serving the retarded are not on a par with those of other agencies. This refers not only to salary levels, but to the important factor of a stimulating working atmosphere

which supports further training, research, and encourages joint work with other professions.

Two major considerations should be stated here. First, the greatest promise for resolving the manpower dilemma appears to rest in the utilization of heretofore untapped manpower resources who can make a contribution through creative changes in staff roles and by assuming delegated professional responsibilities. The preparation of such personnel must come about by greatly expanding inservice training programs and by the development of curricula in junior colleges and other training centers which prepare individuals to carry out newly developed technical and paraprofessional functions.

Second is the concept of ongoing training. A true commitment to the implementation of rapidly changing methods and ideas can only be brought about if provision is made for the continued education of staff through formal education as well as inservice training. Recognition of the sociological and psychological problems related to retardation should be an important component of inservice training.

Ongoing training allows for the necessary continual upgrading of staff skills, contributes to a desirable working climate and makes it possible for all personnel to advance on the basis of their capabilities and initiative.

Manpower requirements for the severely and the profoundly retarded, the majority of whom are in residential centers, differ from the mildly and moderately retarded, the vast majority of whom live in the community.

The medical, educational and direct care responsibilities on behalf of residents in regional residential centers are more clearly understood and more easily identified (despite the many changes taking place) than are similar responsibilities for the retarded living in the community.

Needs of the retarded may often be best met by a coordinated program involving different agencies working with the child and his family from the earliest recognition of the retardation and therefore, providing needed services at each step of the way through adulthood.

Counselling with the family following the child's birth, aiding his admission to preschool nurseries, to special classes in the public school or to a day care program in his area, periodic evaluations of his progress at a local clinic and preparation for a sheltered workshop program or for competitive employment are illustrative of the comprehensive services which must be available to retarded persons in each area, and are an indication of the scope of future manpower requirements.

In a comprehensive community program, a variety of agencies and professions should provide for the adjustment of the retarded person and his family to community life. Agencies and professionals are not seen as serving the retarded exclusively, but as one of a number of disability groups requiring specific professional services. A social worker from a mental health clinic may, as part of her responsibilities, counsel a family with a retarded child; a local general hospital may provide needed physical therapy for a retarded adult, or provide short term patient care for a retarded person with an acute illness.

REEVALUATION OF GRADE AND SALARY CLASSIFICATIONS AT REGIONAL RESIDENTIAL CENTERS FOR THE RETARDED

Major and interrelated developments in the field of retardation are concerned with the movement within the regional residential centers (present state residential schools) away from custodial care to more individual centered programs. A greater stress is now placed on social development and training in skills to support optimum independent functioning, and the establishment and expansion of local services to accomplish essentially similar goals for less severely retarded persons living in the community.

Implementation of these developments within the regional centers will require new staffing patterns and a general upgrading of skills. Staff must often deal, even within the same building, with residents of the very lowest mentality who have not yet learned the fundamentals of self care, and with residents with a moderate deficiency who present behavior problems and emotional disturbances that are poorly understood. Many difficulties are involved in factoring out the different systems of human management necessary to cope with this broad variety of problems. No one system of social management meets the needs of this population. Personnel are necessary who are able to understand and respond appropriately to residents at particular ages and levels of intelligence and develop suitable programs for them.

Vocational training, cottage life direction and guidance, child development, social growth and development, physical education, are features of a well rounded program for the retarded. The presence of this broad mixture of residents in the individual buildings makes it difficult for the matrons and attendants to follow through in social development programs that will be generally helpful. Professional persons who have special knowledge and ability in areas of social and vocational growth must be introduced. Physical education, occupational therapy, recreational therapy and social group work should also be included. Skills of nurses and attendants that concern these areas must be strengthened.

For the quality of services to rise, new types of personnel and an upgrading of the qualifications of present personnel are needed.

In the light of new goals requiring additional skills, grade and salary classifications and job descriptions of all professional, instructional, attendant, clerical, and maintenance personnel of the Department of Mental Health and other departments providing services for the retarded should be reevaluated and periodically reviewed by these departments.

As a beginning, the Legislative Commission on Mental Retardation in collaboration with the proposed Office of Retardation and officials of health, education, and welfare agencies should undertake a study of grade and salary classifications and job descriptions.

Recommendations for upgrading, including tables of organization, job descriptions and grade and salary classifications have been completed in the professional services of psychology, occupational therapy, social work and nursing of the Department of Mental Health. These should be included as part of the over-all recommendations for upgrading undertaken by the Department.

Changing goals and new demands being made upon professionals and nonprofessionals who are working with the retarded will, in many instances, require the upgrading of their skills and over-all qualifications. Many changes will occur in the job rules of existing positions and new positions are already needed. Such drastic changes cannot be patched into the existing framework, but require a full examination of all job descriptions and grade and salary classifications.

NEW POSITIONS IN THE DEPARTMENT OF MENTAL HEALTH AND REGIONAL RESIDENTIAL CENTERS (STATE RESIDENTIAL SCHOOLS)

Illustrative of the urgency of a complete reclassification of all positions within the Department of Mental Health are the

new positions at the central office and the regional residential centers recommended to implement the changing goals, expanding services and new programs being developed for retarded persons at the regional residential centers and within the community.

The positions of Director of Educational Services and Director of Vocational Services should be established in the central office of the Department of Mental Health to reflect the crucial importance of education and vocational programs in providing services to retarded persons.

The position of Director of Physical Therapy Services should be established in the central office of the Department of Mental Health to provide technical consultation and guidance to the physical therapists at the Department's facilities. Such direction presently is available for the professions of psychology, occupational therapy, nursing and social work. As new professional staff services are established at regional centers, equivalent positions to direct and coordinate these new services should be established at the central office.

Recommended new positions at regional centers include:

- A personnel specialist to coordinate the policies and procedures for the more than 500 personnel at each of these facilities.
- A physiatrist to assume responsibility for physical therapy so that the benefits of this professional discipline may be made more available.

The following positions should be established at each of the regional centers to implement a completely reorganized approach to residential programs:

An Assistant Superintendent of Medical Services, an Assistant Superintendent of Management, and an Assistant Superintendent of Social Development, Education and Training (on equal grade levels).

A Director of Community Services, a Director of the Hospital Unit, a Director of the Infirmary Unit, a Director of Children's Services, a Director of Adolescent Services, a Director of Adult Services, and a Director of Research (on equal grade levels).

The following positions should be established at each of the regional centers to implement recommendations on educational programs:

Speech therapist, remedial reading specialist, art teacher, home economics teacher, industrial arts teacher, music teacher, physical education teacher.

INSERVICE TRAINING

Inservice training should be viewed as an ongoing process for upgrading all personnel and providing them with a current knowledge base in their own and in related fields.

Training programs for direct care personnel such as attendants and building supervisors at residential facilities should receive top priority. A review of attendants' roles show, for example, confusing and often contradictory sets of responsibilities — some stressing physical care, others housekeeping functions.

Extensive inservice training programs must be developed to redefine job functions and help staff to concentrate upon helping retarded residents to broaden their environment with a wide range of social learning opportunities. This may be accomplished by orientation and training at the beginning of the attendant's experience and by repeated periods of higher learning and orientation of specialized training. Job increments appropriate to training and responsibility should serve as inducements for participating.

Inservice training for all staff serving the retarded should be combined, when possible, with formal training at colleges, universities, and professional schools. Staff should also have the opportunity to attend conferences and institutes related to their work.

The Office of Retardation should assume responsibility for stimulating inservice training for personnel serving retarded persons in all state agencies with the cooperation and participation of voluntary agencies and professional groups throughout the Commonwealth.

PROGRAM DEVELOPMENT AND RECRUITMENT

Federal Grants

Each of the four state residential facilities for the retarded receives the maximum inservice training grant of $25,000 annually from the National Institute of Mental Health. These grants are for a period of up to seven years and are renewable.

The first major area of grant support was extended to attendants, houseparents, psychiatric aides and others, recognizing that they comprise more than 84% of those rendering direct care and training to institutional retardates. Grant support for inservice training has since been broadened to include all professional, subprofessional, and technical personnel, who have direct responsibilities for resident care and training. These grants are in addition to the support for training of cottage and ward life personnel.

Hospital Improvement Project grants (HIP) have been granted to all of the state residential facilities for the retarded. Each project received $100,000 per year in federal funds for a three to five year period. These projects are specifically focused on the use of current knowledge to demonstrate improved programs of care and services.

Recruiting Problems and Prospects

Higher salaries, improved working conditions and higher professional standards alone will not overcome certain unique recruitment problems in the field of retardation.

Expansion of services in the community and the addition of many new professional and supportive personnel pose additional problems to an already severe manpower shortage.

Employment opportunities in the field of retardation, though expanding, are not widely known among the general population and among students at the high school, undergraduate and graduate levels. Information regarding the field of retardation is generally not included in the curricula at any level. A serious additional obstacle to recruitment is the fear, hopelessness and low status which many persons still associate with work in this field.

Efforts to alleviate these obstacles to recruitment should take place at two levels. On a statewide basis, the Office of Retardation should work with the Board of Education and Board of Higher Education to disseminate information to students, teachers, school administrators and others responsible for curriculum planning and development. Secondly, the recruiting programs conducted by individual facilities and agencies of the Department of Mental Health should be supported and stimulated by the central office.

Information about careers in the field of retardation should be presented to students, teachers and guidance counselors. Printed materials, audio visual aids and speakers should present information at an educational level appropriate to the students.

Of even greater importance is the inclusion of facts about retardation in the curriculum, as one of a number of significant social problems for high school students, and in greater speci-

ficity in advanced and professional curricula. These efforts to improve awareness of retardation should help to recruit young persons to work in the field.

Youth Career Programs

Regional centers and other facilities for the retarded should expand programs to allow young people to have personal contact with the retarded. One day visits, part time small group leadership, positions as summer counselors and full time internships on a paid and voluntary basis, are some of the methods through which prospective workers may be introduced to the field.

The Public Health Service funds a student work experience and a training program for high school and college students. Students can work during the summer and gain experience in agencies serving retarded persons. In the summer of 1966, when the program began, there were 37 trainees from Massachusetts. The success of this and similar experience and training programs should be carefully studied for their influence in effecting career choices.

Tapping New Manpower Resources

Careful consideration should be given to apprenticeship trainee positions for college graduates who may be well suited for positions such as recreation leaders and rehabilitation aides. At least 30 such persons could be used in their capacities at each regional residential center. Personnel should be utilized from among large, untapped manpower pools such as older married women, and persons from low income groups, who may have personal attributes, and some skills for work in recreation programs, workshops, and on wards of residential facilities. Related skills which such personnel may require could be taught in inservice training programs.

Women who still have family responsibilities may be able to make valuable contributions because of their specific skills and prior training. Flexible working schedules might attract many people to fill existing vacancies.

Efforts should be made to recruit people with personal warmth, flexibility and creativity in program planning to foster social development. Personal qualities may be far more important qualifications of direct care personnel than the attainment of a certain educational level or specific prior experience. This is particularly important on wards of residential facilities where morning, afternoon and evening shifts of parent surrogates should be capable of maintaining a consistent homelike atmosphere.

With additional training and experience these individuals may eventually qualify for more responsible positions.

Advancement through further training, promotion and reassignment should be available to all personnel.

Incentive Education

Special provision should be made to pay salary increments to staff members of the Department of Mental Health for additional training related to their work, including professional certificates, advanced degrees and other specified additional training. A raise of one pay grade for the completion of a master's degree and of a doctorate degree has been recommended. Guidelines should be established for pay raises related to specified additional training.

The Department of Mental Health should expand its program of educational leave which presently allows for six months at full pay or one year at one half pay, and reimburses employees for more extensive studies, including provisions for annual promotion and step increases while absent on leave.

Provision should be made in the budget of each facility for substitute personnel to replace those participating in inservice training or on educational leave.

Raising Professional Standards

The educational background and professional experience of supervisory personnel is an important factor in attracting professionals to agencies striving to create a stimulating professional environment for students and new workers. Department heads and other supervisory personnel in professions such as psychology, occupational therapy, social work and nursing should be required to possess the advanced degrees necessary to qualify them as field instructors or supervisors consistent with the student placement requirements of their respective professions.

Higher qualifications of supervisory personnel will also increase the likelihood of affiliations with university training and research centers. University affiliations will open opportunities for research, training, consultation and recruitment, and will raise the professional status of programs so involved.

Career Planning

Specific opportunities for advancement based on job performance, longevity and additional training should be provided for all personnel in programs for the retarded. Career plans are commonly employed in industry. They provide incentive to employees to upgrade their skill and contribute to their morale.

Volunteers

New and imaginative roles for volunteers such as leaders of small groups which foster social development and teach special skills, should be explored by the Director of Volunteers of regional residential centers in view of the new goals to form small groups as the basic structure in the regional centers.

The case aide volunteer program of the Boston State Hospital and Metropolitan State Hospital could be used as models for regional and area programs.

Broadening the Training Base

Many more trained personnel are needed than are now being graduated from training facilities in the health and welfare fields. Qualified candidates for graduate and professional training are being turned away for lack of faculty, space and training fellowship support.

Despite the growth in the number of clinics serving retarded children, and the increase in the number of children served, waiting lists remain long.

With the exception of training programs in special education, a training base for the field of retardation is still undeveloped. Knowledge required to work with the retarded presupposes an interdisciplinary approach. Interdisciplinary training centers for the field of retardation should be explored. These centers would bring together the contributions of a variety of professions and train administrators, supervisors, consultants and specialists in retardation who, irrespective of their primary professional training, will learn about the contributions and the limitations of each professional area and will gain a broad understanding of many treatment and training possibilities.

Federal Training Grants

In 1965, Massachusetts received $172,800 from the U. S. Department of Health, Education and Welfare for preparation of professional personnel in the education of the retarded. An additional $114,698 was granted to train social work students in retardation and vocational rehabilitation. Two

grants of approximately $25,000 each for inservice training at two of the state residential schools were also received. Additional federal training grant programs are now available through P.L. 89–97, which authorizes nationwide appropriations of $5 million for fiscal year, 1967, $10 million for fiscal year 1968 and $17 million for each fiscal year thereafter. These grants must be used in the training of professional personnel for the care of crippled children including retarded children with physical handicaps. Grants are being made to institutions of higher learning for training professional personnel such as physicians, psychologists, nurses, dentists and social workers for those with multiple handicaps.

P.L. 89–105 expands the program of training of teachers in work with retarded and other handicapped children and authorizes its extension through 1969, with annual amounts available to all the states of $19.5 million in 1966, $29.5 million in 1967, $34 million in 1968 and $37.5 million in 1969.

Graduate Fellowships

A further means of expanding the training base rests in the provision of student stipends and graduate fellowship programs. P.L. 88–164 authorizes $19.5 million for fiscal year 1966 for a graduate fellowship program, part of which is being utilized to train more than 2,500 persons in the education of the retarded. As new professional roles in the field of retardation become clarified, expanded fellowship programs for the training of persons in other professions will be needed.

Many federal grants, although they show promise or prove to be of value, are discontinued once federal grant support ends. This lack of an ongoing commitment impedes progress in a number of areas of investigation and loses skilled personnel who must seek employment elsewhere. The Commonwealth should make funds available to continue programs initially sponsored by the federal government which prove to be of value.

Evaluation and Modification of Training Programs

Expansion of professional training must be closely related to research and demonstration since the most effective methods for meeting the needs of the retarded are not yet known. At the present time, there is little objective evidence about the superiority of one method over any other which might lend a clear cut direction to the types of training programs being developed. Research is needed to describe and define the intellectual, emotional, social and physical needs of retarded children and adults. If their educational needs are to be met, it is also necessary to develop effective remedial techniques, classroom procedures, new methods of instruction, special materials, appropriate curricula, and to translate research findings into practical application within the training programs being offered.

A closer link between the schools preparing professionals for the field and the agencies and residential centers serving them, would be an additional means of lending direction to training programs. Regional centers and other facilities should reach out to the schools by providing part time employment for faculty members and by encouraging their staff to teach courses related to their work.

Coordinating Professional Skills

A great deal of stress is being placed upon a "total person" approach in working with disabled persons in a variety of settings. This is a particularly significant goal for retarded persons whose optimum functioning depends upon the coordinated development of his academic, vocational and social skills. The tendency of each profession to assume jurisdiction over certain aspects of the retarded person's training impedes an integrated approach. As specialized skills within each profession grow, overlapping functions increase and blur the most appropriate role a profession should play in a given setting for supporting total, integrated development. No single profession can adequately work with the retarded alone. The interprofessional team approach, though difficult to achieve, is urgently required. It is greatly enhanced by opportunities for informal communication among staff. Professional roles vary from one setting to the next. An integrated working relationship among staff is sometimes best achieved through a clear administrative definition of appropriate staff functions.

Personnel from Junior and Community Colleges

Many of the persons graduating from junior and community colleges are suited for filling paraprofessional and direct care roles such as technicians, teacher's aides, case aides, patient care aides, as well as middle level management positions. Certified occupational therapy assistants are presently being trained at Mount Aloysius Junior College in Pennsylvania and Saint Mary's Junior College in Minnesota. The Board of Regents of Community Colleges in Massachusetts is exploring an aide curriculum for students in this state.

Curricula at junior and community colleges should contain material which will help to prepare persons interested in the field of retardation. The present effort of the Massachusetts community college system to expand its programs in terminal education for the new disciplines in health and welfare should be strongly supported.

FLEXIBILITY IN ADMINISTRATION

Other problems confronting administrators in recruiting and retraining professional personnel could be overcome either by changes in legislation or in administrative regulations.

Approval of federal grants is partly based on the qualifications of the personnel at the agency making application for funds. Professional staff are more likely to be attracted to an agency with highly qualified personnel.

Education requirements for professional personnel under civil service are, at present, forbidden under Chapter 31, Section 6a of the Massachusetts General Laws except for positions related to federal funds. This section should be repealed.

> (Chapter 31, Section 6a Massachusetts General Laws) "Educational Requirements. No rule or regulation shall be made setting up educational requirements as a condition of taking a civil service examination except in respect to professional and other positions for which such requirements are expressly imposed by statute and to the extent of the requirements so imposed. Added St. 1935, c. 228."

Unassembled Examinations

Appointment of professionals should be based on their professional qualifications and experience (unassembled examinations), rather than on the results of special examinations for each position. Under the Nurse Practice Act, for example, nurses are licensed by the Commonwealth for professional practice. In state employment, however, some nursing positions, both in the Department of Public Health and Department of Mental Health, are under civil service, which means that these employees, after already being licensed by the Commonwealth, must be tested a second time.

Temporary Certification of Physicians and Teachers

The Office of Retardation should conduct a one year study of the temporary certificate situation in respect to physicians,

teachers and others, to determine the effect of a change in the present time restrictions.

Authority to Hire Immediately

Superintendents of state institutions are not authorized to fill certain job vacancies until the application has been processed and approved by their department, the Bureau of Personnel and Standardization and the Civil Service Commission. Such a procedure may take as much as five weeks. Many desirable prospective employees are unwilling to wait that long for a definite job commitment. Superintendents should be authorized to make immediate job commitments pending the necessary approval. All personnel should receive salaries pending the completion of processing their applications.

Temporary civil service positions which have been in existence for one or two years and have demonstrated their usefulness should be made permanent so that persons working in these pay blocks will have the status of permanent employees.

EMPLOYMENT AND CONSULTATION AT MORE THAN ONE STATE AGENCY

In view of the serious shortage of professional personnel, regional residential centers and other facilities should explore the feasibility of joint staff appointments with colleges, universities, and other agencies, including those of the state government. Joint appointments may result in a professional working the equivalent of more than one full time position. Part time teaching and consultation in addition to other work are common professional working patterns and can generally be handled without reduced working efficiency, and may serve as an important job inducement. It should be permissible for a person to draw payment from the state treasury over and above his full time salary for additional work performed for another state agency outside of working hours.

MANPOWER RESEARCH

No specific guidelines are available with respect to the kind of personnel and the number of staff necessary to conduct comprehensive community retardation programs. Nor are there any federal guidelines for staffing retardation programs which could be used for guidance. Certain national sources, such as the American Psychiatric Association, the American Association on Mental Deficiency, the Child Welfare League of America, the National Advisory Committee on Sheltered Workshops, and the National Association for Retarded Children, have developed some material on staffing requirements with respect to their own specific concerns.

Criteria for worker-client ratios for services to the retarded are needed in Massachusetts. Available national standards should be scrutinized for the extent of their applicability to the Commonwealth.

An authoritative national survey would do much to assist the states in developing adequate staffing guidelines. The Public Health Service, or the Secretary's Committee on Mental Retardation of the U. S. Department of Health, Education and Welfare should undertake or contract for such a survey.

A comprehensive statewide survey of retardation manpower needs in all specialized facilities should be conducted by the Department of Mental Health to help plan the expansion of training facilities, the provision of fellowships in specific professions, the utilization of junior colleges to fill manpower gaps and the content of inservice training programs. Such a manpower survey should be maintained with current information on the number and types of professionals and other staff being recruited into the field, number of persons being trained, graduates entering the field, staff turnover, numbers of vacancies in each staff category, as well as information on job specifications and salaries.

Research is also needed in respect to the type of skills and training needed by child development personnel and others on a professional and paraprofessional level in fulfilling job roles in the new services being proposed at residential facilities, preschool nurseries, sheltered workshops, group homes and in foster care services. Such research should be explored by the Secretary's Committee on Retardation of the U. S. Department of Health, Education and Welfare.

RECOMMENDATIONS

RETARDATION AND CIVIL LAW

UPDATING TERMINOLOGY

152. The General Laws of the Commonwealth and departmental regulations in which archaic terms, such as "feeble-minded," "mental defective" and "mentally deficient," are used should be amended by substituting the current and more acceptable term "mentally retarded person."

SEPARATION OF STATUTORY PROVISIONS

153. Current sections which pertain exclusively to a mentally deficient, a feeble-minded and a mentally defective person now to be called "mentally retarded person," should be separated in Chapter 123 from sections which pertain to other mental disabilities.

DEFINITION OF "MENTALLY RETARDED PERSONS"

154. A general statutory definition of "mentally retarded person" should be inserted in Chapter 123, Section 1 of the General Laws to which other statutes and regulations dealing with the mentally retarded should make reference.

DEFINITIONS OF "MENTALLY RETARDED PERSON" FOR RELEVANT PUBLIC DEPARTMENTS

155. The Department of Public Welfare, the Division of Child Guardianship, the Department of Education, the Youth Service Board, the Department of Public Health, the Department of Corrections and the Massachusetts Rehabilitation Commission should develop a separate definition of "mentally retarded person" which must be consistent with the general statutory definition of "mentally retarded person" and capable of being cross-referenced.

CLINICAL AUTHORITIES

156. The clinical authority to verify a finding of "mentally retarded person" on the basis of a clinical team evaluation for purposes of satisfying the requirements of involuntary commitment or voluntary admission should be one who meets the qualifications and standards specified in the regulations of relevant public departments. Judges should have the affirmative power to call any member of the clinical team which the Department of Mental Health or other relevant departments specify for these purposes as clinical authorities.

DEFINITION OF DIAGNOSIS

157. A statutory definition of diagnosis and evaluation for purposes of determining a finding of mental retardation should be inserted in Chapter 123. A diagnostic and evaluative study to determine the ability, limitations and needs of the mentally retarded person shall include a medical examination, a psychological and psychometric examination, a social and personality study and educational or vocational analysis.

STANDARDS FOR DIAGNOSTIC AND EVALUATIVE SERVICES

158. Regulatory standards should be developed, authorized and each relevant department should budget for the provision and purchase of diagnostic and evaluation services for persons requiring such services.

REPEAL INVOLUNTARY COMMITMENT SECTION

159. Chapter 123, Section 66 of the General Laws which provides for involuntary indefinite commitments of "fit subjects" to state schools should be repealed.

ADMISSION AND COMMITMENT TO AND THROUGH A CENTRAL PUBLIC AUTHORITY

160. Chapter 123 of the General Laws should be amended to designate the Department of Mental Health as the statutory authority to receive voluntary admissions and to accept involuntary commitments of mentally retarded persons.

AUTHORITY TO TRANSFER WITHIN ALL FACILITIES

161. Chapter 123 of the General Laws should be amended to allow the Department of Mental Health to transfer individuals in its care or custody, in and among all facilities, under its control and supervision.

NEW VOLUNTARY ADMISSION PROCEDURES

162. Chapter 123 of the General Laws should be amended to provide the Department of Mental Health with regulatory authority to develop types of voluntary admissions.

FACILITIES DESIGNATED TO RECEIVE VOLUNTARY ADMISSIONS AND INVOLUNTARY COMMITMENTS

163. The Department of Mental Health should designate by regulations those facilities under its control and supervision which the Department specifies as having the legal authority to receive and accept mentally retarded persons on a voluntary and/or involuntary status for temporary or continuous care.

164. Statutory terms in Chapter 123 which designate the individual who is living in continuous care facilities as "inmate," "pupil," "patient," should be changed by substituting a regulatory term "resident."

165. The statutory term "state school" in Chapter 123 should be changed by substituting a regulatory term "regional residential center."

AUTHORITY TO ADMIT VOLUNTARY APPLICANTS OR INVOLUNTARY COMMITMENTS

166. The Department of Mental Health should specify by regulation the powers, duties and qualifications of persons designated within the facilities under its control to whom it has delegated regulatory authority to admit persons who apply voluntarily or who are committed involuntarily.

AUTHORITY TO COMMIT BY DISTRICT COURT

167. Chapter 123, Section 50 of the General Laws should be amended to correct inconsistencies in the powers of various courts to commit persons to state schools for the retarded. Only district court judges should have the authority to commit mentally retarded children and adults to the Department of Mental Health.

TIME LIMITATION FOR EMERGENCY INVOLUNTARY COMMITMENT

168. Any mentally retarded person on an emergency involuntary commitment should have the right to a judicial hearing within 10 days of the time when he is committed to the facility for the mentally retarded.

DUE PROCESS ON INVOLUNTARY COMMITMENT

169. When a petition is made to the District Court for the involuntary commitment of a mentally retarded adult, all the attributes of due process of law should be afforded the mentally retarded adult.

REPEAL DEFECTIVE DELINQUENT LAW

170. The ineffective law relating to commitment of defective delinquents should be repealed in Chapter 123, Section 113.

MANDATORY PERIODIC JUDICIAL REVIEW

171. A child or adult admitted by his parents or legal guardian voluntarily or involuntarily to the Department of Mental Health should be provided a judicial review at the age of 12, 16, 21 and every 5 years after the age of 21. If the mentally retarded person is not notified of his right to judicial review, he should have the right to leave the institution unless there is sufficient cause shown why the review is not required.

SUBSTANCE OF JUDICIAL REVIEW

172. Periodic judicial review should allow for a comprehensive reevaluation of the "mentally retarded person" who is under care. Component features of this reevaluation should include: the determination of the individual's civil competency, the individual's clinical status and potential for rehabilitation and consideration of alternative dispositions.

POWER TO SUMMON REPRESENTATIVES

173. Chapter 123 of the General Laws should be amended by adding a new section allowing the judge, at the time of initial commitment and at the time of mandatory periodic reviews, the affirmative power to summon before him representatives of all relevant departments and agencies which have the legitimate authority to provide alternative placement for the mentally retarded person under review.

LEGAL ASSISTANCE

174. A program of legal assistance should be implemented for the protection of the constitutional rights of those persons in state facilities in need of such assistance.

175. Administrative mechanisms necessary to implement a legal assistance program should be studied immediately by a legislative commission.

PROTECTION OF CIVIL RIGHTS

176. A study of the status of civil rights of institutionalized mentally retarded persons should be pursued by the Office of Retardation. Current regulatory restrictions on the execution of civil rights by all institutionalized retarded persons should be reexamined in this study.

UNIFORM POLICIES AND PROCEDURES TO ASSIST SUPERINTENDENTS

177. The proposed legal counsel to the Commissioner of Mental Health, in cooperation with the Assistant Commissioner for Mental Retardation and the superintendents of continuous care facilities, should be instrumental in developing new uniform policies and procedures to assist superintendents in making legal determinations for retarded persons in the Department's custody.

SOLITARY CONFINEMENT

178. The Department of Mental Health should be required to appoint an independent panel to periodically visit and review those mentally retarded residents who, under Chapter 123, Sections 35–38, of the General Laws are restrained or confined in a "strong room" or secluded in solitary confinement.

179. Anyone should be able to initiate proceedings when any supervisor, attendant or other employee of any institution who knowingly violates or willingly permits to be violated any standard pertaining to restraints and confinement in solitary seclusion stated in Sections 35, 36 or 37 of Chapter 123. Chapter 123, Section 38 should be amended to state how such proceedings can be initiated.

REPEAL MARRIAGE PROHIBITION

180. Marriage prohibition in Chapter 207, Section 5 of the General Laws should be repealed to insure that all persons capable of assuming the responsibility of marriage have the right to do so.

DETERMINATION OF COMPETENCY

181. A provision in Chapter 123, comparable to the one for the mentally ill, should state that a finding of mental retardation for purposes of involuntary commitment to a facility for the mentally retarded shall not in itself import a finding of civil incompetency or criminal irresponsibility.

GUARDIANS FOR RETARDED PERSONS

182. Chapter 201, Section 6 of the General Laws should be amended to include mentally retarded person for purpose of appointment of a guardian, comparable to the provision for the mentally ill.

ESTABLISHMENT OF A DIVISION OF ADULT GUARDIANSHIP

183. The Office of Retardation should implement a study on the feasibility of establishing a Division of Adult Guardianship.

EXTENSION OF FOSTER HOME PLACEMENT

184. A more extensive program should be developed through the Department of Mental Health and the Division of Child Guardianship of the Department of Public Welfare by which the existing use of foster home placement for institutionalized mentally retarded children could be further implemented when this type of placement serves as an appropriated alternative to institutionalization.

EQUAL TREATMENT IN FOSTER HOME PLACEMENT

185. The Division of Child Guardianship policy statement on independent foster home rules and regulations now governing the care of children in independent foster homes should be amended to allow retarded children to be placed with normal children in independent foster homes licensed by the Division of Child Guardianship.

GUARDIANSHIP AFTER THE AGE OF 21

186. "Mentally retarded persons" under the care of the Division of Child Guardianship should be provided services beyond the age of 21. Chapter 119 should be amended to make the provision of services possible beyond the age of 21.

RETARDATION AND CRIMINAL LAW

JUDICIAL HEARING ON COMPLAINT

187. Prior to the order for pretrial observation under provisions of Chapter 123, Section 100 to a state mental hospital, a judicial hearing on the complaint should take place.

PROCEDURES FOR IDENTIFYING THE DEFENDANT AS RETARDED

188. A clinical opinion by a qualified physician, specified in the rules and regulations of the Department of Mental Health, should be sought prior to the observational commitment under Chapter 123, Section 100 to support the necessity for such observation to avoid unnecessary state hospital observations, except in instances of urgency or the unavailability of a physician.

189. The Department of Mental Health should designate, in those areas of the state where court clinics do not now exist, a diagnostic and evaluative facility which meets its service and personnel standards which can be available to district and superior courts requiring clinical evaluation of persons brought before the court on criminal, delinquent or wayward child complaint.

DUE PROCESS ON PRETRIAL COMMITMENT

190. When commitment on a pretrial criminal, delinquent or wayward child status beyond the observational period is planned by the court, the accused and his family or guardian ad litem should be served notice of the court's intention and he, his parents or guardian should have the right to challenge the commitment and the right to: court appointed counsel; a hearing within 10 days of the petition for same; an independent psychiatric examination and opinion at the request of defense counsel.

RIGHT TO NOTICE AND HEARING WITHIN SIX MONTHS AFTER PRETRIAL COMMITMENT

191. At the expiration of six months of a pretrial commitment, notice of the right to require a hearing should again be afforded the committed pretrial person.

192. The criminal status of a committed pretrial person should cease at the expiration of what would have been the date of parole eligibility had he been tried and found guilty. Sentence should be concurrent for multiple charges. Further commitment should be civil by new proceedings and the state should nolpros the charges.

193. Where defense counsel may in good faith be able to present evidence which could materially reduce or bring about the dismissal of charges against an incompetent committed pretrial defendant, he should be able, on his own motion, to do so where the grounds are other than those of mental retardation.

194. A superintendent of a state facility should be able to petition the committing court for relaxation of specific restrictions for a person on pretrial commitment.

COMPETENCY FOR TRIAL

195. Definition of competency for trial should be included in the statutes and it should be clearly distinguished from considerations as to committability and criminal responsibility.

INDEFINITE CIVIL COMMITMENT

196. Following pretrial observation at Bridgewater State Hospital and on the recommendation of the medical director at Bridgewater, civil commitment should be permitted to a regular state facility under the control of the Department of Mental Health. Where the alleged offense was a misdemeanor, but where it can be shown that the individual constitutes a serious menace to the community, maximum security institutionalization should be provided at the Massachusetts Correctional Institution, Bridgewater.

CRIMINAL RESPONSIBILITY

197. The first paragraph of the American Law Institute's standard for criminal responsibility should be seriously considered as a standard in Massachusetts.

"NOT GUILTY BY REASON OF MENTAL RETARDATION"

198. A "retarded person" who is "not guilty by reason of mental retardation" who requires commitment should be committed on a civil procedure.

The institution which plans to discharge such an individual should have an additional check on its prerogative to do so by the concurrence of the Department of Mental Health in the decision.

VALIDITY OF CONFESSION OF RETARDED PERSON

199. Those responsible for the administration of justice should be particularly cognizant of the "mentally retarded person" who often, in his wish to please and to be approved of, inadvertently waives procedures which protect his civil rights. There should be no interrogation of a "mentally retarded person" unless an attorney is present.

YOUTHFUL RETARDED OFFENDERS

200. A legislative study commission, proposed by the Attorney General's Advisory Committee on Juvenile Crime in its report of February 2, 1966, to study the substantial number of retarded children who are committed to the Youth Service Board should be immediately undertaken.

In addition, this legislative study commission should consider those children between the ages of 7–17 who are on pretrial observation under provisions of Chapter 123, Section 100 at the Gaebler Unit, Metropolitan State Hospital, and at other state hospitals under the control of the Department of Mental Health.

COMPLETE LEGAL REVISION NEEDED

In a great many ways, the law influences the extent to which the retarded benefit from advances in knowledge and organizational changes which provide new alternatives in care and treatment. Changing social concern about the retarded by the general public, greater medical sophistication about disabilities and new judicial opinion about legal rights of the uninformed, all provide a solid basis for the development of greater clarity, consistency and flexibility in laws that deal with retarded persons.

Legislation for the reorganization of the state Department of Mental Health is concerned with the development of new administrative structures to serve as basic channels for the delivery of programs and services to the retarded. Concurrently, two special legislative commissions of the General Court — one for mental health and one for mental retardation recommended drastic revisions in some of the legal procedures affecting the retarded. The *President's Panel on Mental Retardation Task Force on Law* examined the relevant legal issues and made recommendations providing standards and guides. The redrafting of statutes that deal with admission and commitment of retarded persons is now under review in Massachusetts. In this environment of social, medical, and legal concern, recommendations have been developed which seek to assure the retarded equal protection under the law.

A survey of the laws affecting the retarded indicate that the existing laws do not reflect current knowledge about retardation. The law must respond and adjust to current understandings to perform its proper function in respect to the retarded. Therefore, a complete revision of statutes and regulations affecting the well being of the retarded should be undertaken without delay. Special attention should be given to a comprehensive overhaul of Chapter 123 of the General Laws.

Five areas of major concern isolated for legislative action are:

- Legal definitions.
- Legal provisions for detection and diagnosis.
- Legal provisions for admission, commitment, release and discharge.
- Legal provisions for the appointment of guardians.
- Legal determination of competency to stand trial and legal determination of criminal responsibility.

In developing recommendations, consideration was given to preparing the way to fulfill prerequisites for effective revision of the law. This section aims to clarify the issues facing the retarded and to provide a basis for promoting a sense of awareness of the legal implications of existing and planned programs for the retarded in Massachusetts.

The next step is legislative action.

Revision of civil law relating to the retarded should be based on the following principles:

- Retardation is a social condition which cannot be dealt with exclusively in a medical context.
- Diagnosis and evaluation of retardation require the contributions of a number of professional disciplines and the active participation of the court.
- Institutionalization is only one of a variety of dispositional alternatives which may benefit a retarded person brought before the court.
- Periodic judicial reevaluation of institutionalized persons is necessary to insure the individual's right to treatment in the institution and his right to return to the community as soon as possible.

Legal recognition of these principles, coupled with increasing cooperation among the medical, behavioral and legal professions, will provide a durable foundation for developing a sound legal concept of retardation: a concept consistent with new understandings of retardation and protection of the rights of retarded persons.

DEFINITIONS

Updating Terminology

Uniformity and consistency in the use of legal terms will assist the judiciary, administrators of departmental programs and the general public. The complexity and lack of clarity which characterize current statutory terms such as "idiot", "feeble-minded", "mental defective" and "mentally deficient" will be improved upon by substituting the term "mentally retarded person" for all other terms describing this individual. This term has common usage in law, administration and popular communication.

Separation of Statutory Provisions

Great confusion exists in the statutes concerning the distinctions among the mental disabilities. Traditionally, there has been a division between mental diseases and mental defects. In the current redrafting of Chapter 123 of the General Laws, sections intended to apply to the general population should be clarified. Sections intended to apply to retarded persons should be separated from sections which pertain to other mental disabilities.

A General Legal Definition of "Mentally Retarded Person"

A general statutory definition of "mentally retarded person" will establish a standard as to the meaning of retardation and will assist all major public departments to develop more consistent standards and terminology in the future. The proposed definition of "mentally retarded person" for Chapter 123 of the General Laws is:

> a person who, as a result of inadequately developed or impaired intelligence, as determined by clinical authorities, is substantially limited in his ability to learn or adapt, as judged by established standards available for the evaluation of a person's ability to function in the community.

Definitions of "Mentally Retarded Person" for Relevant Public Departments

Major health, education and welfare departments of the state reported many retarded individuals among their clients. Statutes governing the activities of these departments have little reference to the retarded. Nonetheless, these statutes and the programs they authorize have a significant impact on how many retarded persons residing in our Commonwealth are treated. In some instances, lack of specificity in the law about the implications of retardation as a limitation may be desirable. In other cases, general application of the law without consideration for the factor of retardation may impose a hardship both on the individual and on the department which seeks to serve him. Therefore, each major public department directly serving large numbers of retarded persons should develop a separate definition of retarded person, either by statute or regulation, consistent with the proposed general statutory definition.

DETECTION AND DIAGNOSIS

Clinical Authorities

Existing regulations of the major departments outlining criteria for diagnosis and evaluation of the individual for various reasons are seriously lacking. Minimal standards for diagnosis and evaluation should require that certain ingredients be present. The recommended general statutory definition maintains that a finding of retardation must be established by "clinical authorities". Each relevant department should establish standards for the qualifications of the person designated as the "clinical authority". A team of specialists who can assure differential diagnoses and a spokesman for that team should constitute the minimum standard when a diagnosis and evaluation is required. Each specialty such as medicine, clinical psychology and social work brings to the diagnosis and evaluation a particular aspect of the evaluation for the individual. Judges of district courts should have the affirmative power to call any member of the clinical team who contributed to the diagnosis and evaluation, when a diagnostic opinion is legally required.

A Statutory Definition of Diagnosis

Each day persons in the Commonwealth are being designated as retarded for purposes of institutionalization, admission to special classes and eligibility for rehabilitation and welfare services. Labeling a person as retarded and the potential danger of mislabeling, places a formidable responsibility on departments caring for retarded persons. To assure that the attributes of accepted professional knowledge and practice are employed, a statutory definition of diagnosis and evaluation should be developed.

Regulatory Standards for Diagnostic and Evaluative Services

Statutes and regulations governing the relevant departments of the Commonwealth do not assure differential diagnoses. Some statutes have general provisions for certain types of examinations which do not adequately cover the known elements that exist in a condition such as retardation and do not provide for the practicing knowledge of a team of specialists. Therefore, each department should develop standards for the purchase and provision of diagnostic and evaluative services to assure that individuals are appropriately diagnosed before the definition "mentally retarded person" is applied. Standards set by the U. S. Public Health Service should be used as a guide for new departmental diagnostic and evaluative regulations. These standards include coordinated medical, psychological and social services, supplemented when appropriate by nursing, educational or vocational services. Examinations should be carried out by personnel

qualified to: (a) diagnose, appraise, and evaluate mental retardation and associated disabilities and the strengths, skills, abilities and potentials for improvement of the individual; (b) determine the needs of the individual and his family; (c) develop recommendations for a specific plan of services to be provided with necessary counselling to carry out recommendations, and (d) where indicated, periodically reassess the progress of the individual. Regulations dealing with diagnostic and evaluative provisions of each relevant department should be filed with the Secretary of State and submitted to the Office of Retardation.

ADMISSION AND COMMITMENT

New Criteria for Involuntary Commitment

Present provisions for involuntary commitment are inadequate to meet accepted medical, legal and social standards. Currently, a person may be deprived of his liberty solely on the basis of being a social nuisance.

As recommended in the current redraft of Chapter 123 of the General Laws, general criteria are preferred over specific criteria which singles out retardation or some other disability in all cases where an individual is forceably removed from the community and involuntarily restrained in a public institution. Rights of a retarded person should be rigorously safeguarded by requiring a strict standard for commitment applicable to all persons. Nobody should be involuntarily restrained and face the possibility of total deprivation of liberty.

Admission and Commitment To and Through a Central Public Authority

Historically, Massachusetts institutions for the care and treatment of the mentally ill and the retarded preceded the establishment of the Department of Mental Health. Because of this growth pattern, the statutes allowed courts to commit individuals directly to an institution through the local superintendent. In the proposed reorganization of the Department of Mental Health, the delivery of programs and services throughout the state and the development of area and regional jurisdictions require more centralized direction and flexibility among all the Department's units. The Department of Mental Health should be designated as the statutory authority to receive voluntary admissions and involuntary commitment of persons coming under its care. This recommended statutory provision would clear up the present confusion in the statutes as to whether or not the superintendent of an institution is the legal representative of the Department of Mental Health.

The new provision would allow the Department of Mental Health to delegate its legal authority to personnel in appropriate jurisdictions of the state who would serve as legal representatives of the Department for purposes of admitting persons to its facilities.

New Voluntary Admission

Currently, voluntary admission procedures are defined in the statutes. The Department of Mental Health should be provided with the regulatory authority to develop various types of voluntary admission procedures to meet the needs of the facilities under its control and the persons who seek services voluntarily at these facilities.

One suggested voluntary procedure should provide service for a short period of time, not to exceed 60 days for any one admission. The admission could be repeated at intervals of necessity throughout the life of the individual.

Another recommended voluntary procedure should be called "continuous care" admission. This procedure would identify those persons who will be subject to periodic judicial review.

Designated Facilities to Receive Voluntary Admissions and Involuntary Commitments

The Department of Mental Health, as the statutory authority of all mental health and retardation area and regional jurisdictions, facilities, programs and services under its control and supervision, should specify those facilities which can receive persons on a voluntary or involuntary status in temporary or continuous care. To provide for viable delivery of services and easy access to services, a statutory provision should allow the Department to utilize any of its institutions for any of the persons who come under its care.

Statutory terms which now apply to persons in residential facilities, such as "inmate," "patient," "student," should be clarified and subject to departmental regulation. Titles used for facilities such as "state school" should be changed to "regional center."

Authority to Admit Voluntary Applicants or Accept Involuntary Commitments

Traditionally, the powers and duties of superintendents have been specified in the statutes. These powers, duties and qualifications should be developed by regulation under the authority of the Department of Mental Health. In developing these regulations, the Department of Mental Health should specify the legal status of persons who come under the custody of a local representative of the Department of Mental Health.

District Court — Authority to Commit

In the future, only district court judges should have the authority to commit to the Department of Mental Health. This action will clarify the current inconsistencies between the authority of the probate and the district court.

Chapter 123, Section 50 provides authority to a justice of the superior court in any county, the judges of the probate court for Suffolk County, the judge of probate court for Nantucket County or a justice or a special justice of the district court, except the municipal court of the city of Boston, to commit a person to any institution for the mentally ill. This section applies to the commitment of retarded persons as well.

Time Limitation for Emergency Involuntary Commitment

Ten days should be the maximum amount of time a person may be held on involuntary status without judicial hearing. Other states have experimented with a 72 hour provision and have found difficulty in carrying it out.

Because of the present court districts in Massachusetts and the large number of communities served by any one residential institution, a 10 day provision seems to be the most feasible time limitation. The opportunity for a person to apply for a voluntary status should be made immediately after admission.

Due Process on Involuntary Commitment

All the attributes of due process of law should be accorded the retarded person when he is involuntarily committed. These attributes include: the right to notice, the right to a hearing, the right to waive hearing, access to counsel or to court appointed counsel and access to independent medical opinion.

Repeal the Defective Delinquent Law

The present law dealing with the socalled defective delinquent (Chapter 123, Section 113) does not require actual

conviction of an alleged criminal offense. It does allow a person who is defective and delinquent to be given a life sentence in a maximum security institution for trivial offenses. Establishment of the Male Defective Delinquent Department at Bridgewater under the Department of Correction in 1911 has been described by a leading authority in the correctional field as a "sociological error" of that time. Through the years of its existence, it has been marred by a history of illegal commitments and hazy outlines as to what constitutes a defective delinquent. This section should be repealed. The 150 men currently hospitalized, some for many years, at the Defective Delinquent Center at Bridgewater should be continued on civil commitment status similar to Section 51 in Chapter 123.

This proposal would provide flexibility of management of these men and an opportunity for trial visit in the community consistent with modern medical practice. An abrupt transfer of the men currently committed to the Defective Delinquent Center would be inhumane since many have lived at the institution for many years and would be very threatened by any change in their domicile. A similar disposition should be made of females currently committed to the Massachusetts Correctional Institution at Framingham under Chapter 123, Section 113. Such transfer should be effected when feasible and consistent with the best interests of the patient and the community.

CARE AND CUSTODY

Mandatory Periodic Judicial Review

Historically, with the absence of certain provisions in the law, a retarded person was assumed to have a chronic condition. Once he was committed to a public facility, the state would assume legal custody and the provision of long term care. Many retarded persons, due to the absence or death of natural parents, resided in institutions without appointed guardians. The superintendent, as legal custodian, has in most of these instances assumed the role of guardian, as well as legal custodian, although the powers and duties of each role differ significantly.

In addition, the traditional doctrine of parental rights which gives parents full control and authority over their minor children, allows parents to admit their children voluntarily, even though the child may protest the act of his parent.

Mandatory periodic judicial review of voluntary admissions and involuntary commitments should be made of all persons in residential institutions for the retarded. Reviews should begin at the age of 12 and be repeated at the ages of 16 and 21 and every five years after the age of 21. This proposal is an attempt to develop a mechanism to assure persons a comprehensive review and see that they will not be forgotten by society.

As the final institution of authority in society, the court has the pivotal role of mobilizing representatives legitimately responsible for the provision of alternative solutions for the care of the retarded person.

Substance of Judicial Review

Periodic judicial review should not be allowed to degenerate to a perfunctory procedure. A section of Chapter 123 should specify the elements involved in a periodic judicial review. The determination of an individual's civil competency and the potential inquiry into the need for appointment of a guardian, the individual's current clinical status, and his potential for his return to the community, should be considered in an atmosphere of coordinated social, medical and legal planning.

Power to Summon Representatives

Many judges now perceive the court of law as a progressive social institution responsible for assuring that judicial dispositions represent the most beneficial choice among a series of choices. Viewed in this light, the court should have affirmative access to legitimate agencies who represent these choices. Therefore, at the time of mandatory judicial periodic reviews, the judge should summon before him representatives of all the relevant agencies and departments, the guardian, the parents or others who have legitimate interest and authority to provide alternative solutions for the future care of the person under review.

A Program of Legal Assistance

There is a growing concern throughout the country about the initiation of new programs of legal assistance to persons residing in state facilities. The concept of a "legal aide approach" has grown out of areas of need not adequately served at present. These include: the regular provision of notice at time of periodic review; legal counsel concerning the exercise of civil rights and privileges, such as the right to contract, to make a will, the right to vote, to hold an occupational or professional license, and privilege of driving an automobile. Independent legal counsel should assist persons residing in state facilities. In addition, the legal assistant or legal counsel could assist children without parents or guardians by initiating procedures for the appointment of guardians. By the nature of his expert legal training, independent legal counsel could provide the kind of legal advice which is now spasmodically or inexpertly provided by traditional mental health and retardation professionals.

A beginning research interest in Massachusetts in this area of concern should be further pursued by the immediate initiation of a study for a program of legal assistance by a legislative commission. The study should consider appropriate auspices and location for such a legal assistance program.

Protection of Civil Rights

Concurrent with interests in the development of a legal assistance program, an immediate study should be made regarding the civil rights of retarded persons institutionalized in the state. Regulatory restrictions on the civil rights of all institutionalized persons, particularly those under commitment, should be thoroughly examined in this study.

Uniform Policies and Procedures to Assist Superintendents

Problems associated with the appointment of guardians, the determination of the competency of an individual to make contracts, and the general execution of the civil rights of patients, should be the subject of uniform policies and procedures initiated by the Department of Mental Health to assist those persons who legally represent the Department in the facilities, programs and services through the state. Those directors of facilities who have legal custody of persons in continuous care should have expert legal counsel available to them in the Department of Mental Health.

Use of Solitary Confinement

If a resident of a state residential school for the retarded requires disciplinary measures, the measures should be administered under uniform rules and regulations. The practices under these rules and regulations should be subject to periodic review. Solitary confinement should not be used indiscriminately. Offenses which constitute violation of the law should be handled by complaint and appropriate court procedure.

As a consequence, the Department of Mental Health, as the statutory authority for the care and treatment of persons in its custody, should be required to appoint an independent panel to periodically visit and review persons in residential facilities who are secluded in solitary confinement.

In the redrafting of Chapter 123, Section 38 should be amended to specify who can initiate proceedings when supervisors, attendants or other employees violate standards pertaining to restraints and confinements of persons in state facilities.

At present, Section 38 states that such a person can be punished by a fine of not less than $50 nor more than $300, but not who can initiate proceedings. Any person should be able to file a written complaint with a justice of a district court stating that he has reason to believe that a person named in such complaint is violating standards pertaining to restraints or confinement.

Repeal Marriage Prohibition

All persons who are capable of assuming the responsibility of marriage should have the right to do so. Chapter 207, Section 5 of the General Laws states in part that "an insane person, idiot, or a feebleminded person under commitment to an institution for the feebleminded, in the custody of, or under supervision of the Department of Mental Health, or in an institution for mental defectives, should be incapable of contracting marriage." Since retardation or institutionalization should not import incompetency to enter into a contractual relationship, this statute restricting the right to marriage on the basis of retardation should be repealed.

GUARDIANSHIP

Judicial Determination of Competency

Current definitions of "feebleminded," "mentally deficient" and "mentally defective" persons suggest that such a person is incompetent, or describe him as "incapable of managing himself and his own affairs." To assure that a finding of retardation does not imply incompetency, a provision comparable to the current one in Chapter 123 for the mentally ill should assure individuals who enter public facilities that retardation does not concurrently import a finding of civil incompetency or criminal irresponsibility. This provision will serve to increase public awareness and community responsibility concerning the protection of the civil rights of retarded persons. Such persons should have the right, regardless of the defined state of retardation, to manage their own affairs unless a court rules that they are unable to do so.

Guardians for Retarded Persons

Guardianship is a legal mechanism which may be used to guard the rights and liberties of a retarded person when he cannot guard them for himself. Unfortunately, guardians or conservators for the retarded in our state schools are seldom appointed unless a sum of money is involved. When money is involved and a guardian is secured, the guardian very rarely develops a personal relationship with the retarded ward. He is simply a conduit through which the funds of the retarded person flow to the Department of Mental Health. Increased efforts should be made to assure that long term residents in state schools, without natural parents by reason of death, should be the object of public concern in assuring that guardians are found and appointed. There are a large number of retarded residents in the community who can sustain themselves except in times of emotional or economic stress. If a social guardian is available to assist a retarded person, the chances of a social breakdown requiring institutionalization can be avoided.

There is no way to discover from the records of the probate courts whether a person placed under guardianship is retarded. By amending Chapter 201, Section 6 and inserting "mentally retarded person," the criteria for appointment becomes sharper than the criteria which now exists in the general provisions for the appointment of a guardian in the current law. The amendment to Chapter 201, Section 6 would allow two or more relatives or friends of a retarded person, or the mayor or alderman of a city or the selectman of a town in which the retarded person is an inhabitant or resident or the Department of Mental Health, to petition the probate court for the appointment of a guardian.

Division of Adult Guardianship

There are many retarded adults residing in the Commonwealth who would be able to manage their life affairs with greater ease with the assistance of a guardian.

To explore the feasibility of establishing a protective service for retarded adults, such as a Division of Adult Guardianship, the Office of Retardation should implement a study about three distinct groups of retarded persons:

- Retarded adults who were formerly wards in foster homes under the authority of the Division of Child Guardianship.
- Retarded adults in state schools whose natural parents have died and there is an absence, after search, of blood relatives, or next of kin.
- Retarded adults living in the community who could benefit in the management of their affairs from the assistance of a social guardian upon the death of their natural parents.

Extension of Foster Home Placement

Tentative and informal arrangements now existing between some of the Division of Child Guardianship district offices and the superintendents of state schools for the retarded by which foster home placement is secured for retarded children in the institution should be further developed. A more formal policy arrangement should be developed through the Department of Mental Health and the Department of Public Welfare whereby close collaboration concerning the feasibility of foster home placement is used initially as a positive placement alternative to institutionalization.

Equal Treatment in Foster Home Placement

To increase the possibility for normal living and to assure retarded children access to equal opportunity, retarded children should be able to be placed in independent foster homes with normal children. This policy would be consistent with the rules and regulations that the Division of Child Guardianship now has for foster homes under its immediate control and supervision.

Guardianship After the Age of 21

Until such time as the feasibility of a Division of Adult Guardianship is thoroughly studied, the current statutory limitation on the Division of Child Guardianship's authority to provide services to persons over the age of 21, should not apply if the person in their care is retarded. The support, advice and supervision rendered by the Division of Child Guardianship would provide meaningful encouragement to retarded persons who otherwise might have no comparable recourse at the age of 21.

STATUTORY REFERENCES

A list of the major statutes which formed the basis of the Planning Project's study and recommendations follows:

Definitions Applied to Retarded Persons

Department of Mental Health	Ch. 123 §1 Mental Deficiency Ch. 4 §7 Statutory Construction Ch. 441 Article 2G Interstate Compact plus regulations
Department of Corrections	Ch. 123 §113 Defective Delinquent
Massachusetts Rehabilitation Commission	Ch. 6 §77 Disabled Person
Department of Education	Ch. 71 §46 and regulations
Department of Public Health	None
Department of Public Welfare	None
Division of Youth Service	None
Division of Employment Security	None

Diagnostic Services — Tests — Examinations (not limited to retardation)

Department of Mental Health	Ch. 123 §5, §102
Department of Public Health	Ch. 111 §121A, §110A
Division of Youth Service	Ch. 119 §68A, §68C Ch. 120 §5
Department of Corrections	Ch. 127 §39, §16
Department of Public Welfare	None
Division of Child Guardianship	Ch. 119 §32 plus regulations

Admission — Commitment Procedures

Department of Mental Health	Ch. 123 §22A, §24, §47, §66, §66A, §67, §86A
Department of Public Health	Ch. 111 §69A, §69E, §79
Division of Child Guardianship	Ch. 119 §23D, §24, §26
Department of Corrections	Ch. 127 §97, §111A, §117 Transfer Provisions
Division of Youth Service	Ch. 119 §58, §58A Ch. 120 §6

Discharge and Parole

Department of Mental Health	Ch. 125 §5, §22A, §46, §88A, §89, §89A, §89B, §91, §92, §93
Division of Youth Service	Ch. 120 §6, §12, §16–21

Guardianship or Custody (not limited to retardation)

Department of Mental Health	Ch. 66A
Department of Public Welfare	Ch. 118A §12; Ch. 118D §21
Division of Child Guardianship	Ch. 119 §23, §25, §26, §27
Division of Youth Service	Ch. 119 §58, §68B Ch. 120 §6A, §7, §23
Department of Corrections	Ch. 125 §14
General Provisions	Ch. 201 §1

The Defective Delinquent

Department of Mental Health	Ch. 123 §113–124 Ch. 265 §13–29 Ch. 266 §1–5A, §11–19, §101, §102, §107 Ch. 272 §34 Ch. 274 §6

Note: Competency for trial and criminal responsibilities are covered in the Criminal section.

Commitment to state hospitals (including Bridgewater State Hospital, administered by the Department of Correction) of individuals in a criminal, delinquent or wayward child status is considered in this section. *Retarded persons are subject to these procedures as are all persons against whom complaints, charges and indictments are brought under Massachusetts criminal law.* Chapter 123, Section 100 through 105, Chapter 277, Section 16 and Chapter 278, Section 13 of the General Laws are the relevant statutes.

JUDICIAL HEARING ON THE COMPLAINT

Chapter 123, Section 100 provides that when a person is under complaint or indictment for any crime, or a child between seven and 17 years of age is complained of as a delinquent or wayward child, the court may commit him to a state mental hospital for pretrial observation for a period of 35 days. If a finding is forthcoming from the superintendent that the person is mentally ill or in such mental condition which requires commitment, the person can be indefinitely committed and remain indefinitely on a criminal, delinquent or wayward child status on the basis of a complaint without hearing or trial.

This practice should be terminated by amending Chapter 123, Section 100 to make a judicial hearing on a criminal, delinquent or wayward child complaint mandatory before a pretrial observation order (Section 100) or commitment order (Section 105) is set in motion by the superintendent and/or the court.

IDENTIFYING THE DEFENDANT AS RETARDED

Fourteen district courts and the one and only juvenile court in Massachusetts have court clinics which provide the courts with clinical opinion about the mental condition of the defendant. Studies conducted by the research staff of the Boston University Law-Medicine Research Institute have shown that a clinical screening mechanism greatly assists the court in preventing unnecessary state hospital observations. Having clinical experts in mental health and retardation available to the district courts prior to pretrial observation saves the Commonwealth considerable expense, avoids the indignity to an individual of undeserved incarceration in a state hospital for 35 days, and relieves already overburdened state mental hospital personnel who must confine the so-called "prisoner" during his observational period. Only in cases of urgency or due to the unavailability of the clinical expert should the court utilize the pretrial observational order initially.

For the district courts and the superior courts which now have clinical personnel, greater efforts should be made to raise the standards for numbers and kind of diagnostic and evaluative personnel by securing at least a minimal team of specialists; a psychiatrist, clinical psychologist and social worker. At present, in many instances only one physician is available. For those sections of the state in which district and superior courts do not now have court clinics, the Department of Mental Health should designate a diagnostic and evaluative facility upon which the courts could call for clinical

evaluation of the person on complaint before the court. Court clinics should reflect the standards set by the proposed legal definition of diagnosis in the civil section.

DUE PROCESS ON PRETRIAL COMMITMENT

At present, in Massachusetts, a person on a pretrial observational criminal status can be recommitted indefinitely without notice to himself or his family. There is no provision for court appointed counsel. In addition, there is no provision for the termination of the individual's criminal status as long as the initial charges or complaint remain. Currently, a person who has had his day in court, has been convicted and sentenced, has the opportunity to be examined by two physicians. His criminal status expires at the end of his sentence, even if it is spent in Bridgewater State Hospital. If on the expiration of his sentence he is still in need of mental hospital care, he now is recommitted on a civil status. The rights of the convicted felon are far more stringently protected than are those of persons accused of misdemeanors, many of which are petty, in anyone's eyes. A man accused of walking on the railroad tracks has been incarcerated in Bridgewater for 40 years on a pretrial status. This practice seems highly unwarranted in the light of modern concepts of law, medicine and social justice. The accused person must be represented by counsel. Court should appoint counsel and the defense counsel should request and receive an independent diagnostic opinion of the defendant's mental status.

RIGHT TO NOTICE AND HEARING WITHIN SIX MONTHS AFTER PRETRIAL COMMITMENT

If a finding of "mental retardation" is made and the retarded person is committed on a pretrial status, there should be a judicial review of the commitment within a six month period. This commitment, which is intended to be temporary, can, in effect, result in a lifetime of imprisonment. The criminal status could cease at the expiration of what would have been, if the person was tried and found guilty, the date of parole eligibility. Prolonged commitment on a pretrial status, for the individual who is retarded, should be based on a civil procedure. When an incompetent pretrial retarded defendant is assisted by counsel, the counsel should be allowed to introduce on his own motion evidence, other than evidence of retardation, which could reduce or bring about the dismissal of the charges. To promote the rehabilitation of a retarded person who is on pretrial criminal commitment, the superintendent should be able to petition the court for relaxation of certain aspects of maximum confinement. Only when the retarded person has an opportunity, under the appropriate supervision, to have real life experiences, can there be assurance of his eventual capacity to maintain himself within the demands of a free community. The philosophy of "total security" or "no security" can be abusive to the retarded person and ultimately to society.

NEEDED STATUTORY DEFINITION OF COMPETENCY FOR TRIAL

There is presently no definition of competency for trial in the general laws. Competency for trial should be clearly distinguished as an entirely separate issue from the need for commitment or the issue of criminal responsibility. A standard which states that a finding of mental retardation shall not signify a finding of civil incompetency or criminal irresponsibility — should be complemented by a definition which statutorily defines "competency for trial."

INDEFINITE CIVIL COMMITMENT WHEN MISDEMEANANT REQUIRES MAXIMUM SECURITY

Indefinite civil commitment as now provided by Chapter 123, Section 51 should apply to a misdemeanant. This recommendation would replace the necessity of the defective delinquent provision in Chapter 123, Section 113. The civil section calls for the repeal of the defective delinquent provision. However, after the superintendent has shown sufficient cause as to why the person, if released, would constitute a serious menace to the community, maximum security institutionalization should be provided.

CRIMINAL RESPONSIBILITY — A RECOMMENDED STANDARD

The American Law Institute has developed a standard for the determination of criminal responsibility; Section 4.01, Mental disease or defect excluding responsibility. This standard states that "a person is not responsible for criminal conduct if at the time of such conduct, as a result of mental disease or defect, he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirement of law." For purposes of Massachusetts law "mental retardation" should be inserted after the term mental disease.

This standard allows for a less restrictive rule of criminal responsibility and reflects more closely than the present law a contemporary knowledge of retardation.

"NOT GUILTY BY REASON OF MENTAL RETARDATION"

"Not guilty by reason of mental retardation" can be a mixed blessing. Commitment for life in a criminal status can be and usually is the disposition. If a finding of "not guilty by reason of mental retardation" is made and institutionalization is ordered, the retarded person should be committed on a civil procedure. When the institution to which the individual is committed plans to discharge him, an additional check on its prerogative to do so should be provided by the commissioner of the Department of Mental Health.

VALIDITY OF CONFESSION OF THE MENTALLY RETARDED PERSON

A retarded person may be unable to understand police procedures and may be unaware of his constitutional rights to refuse to answer incriminating police questions and of his right to counsel. His confession may be more "nonvoluntary" than "voluntary" in that the retarded person is vulnerable in an atmosphere of threats and coercion as well as submissive in a friendly atmosphere designed to induce confidence. A retarded person molded into a pattern of submissiveness often allows others to place blame on him so that no one will be angry with him. When the police have reason to believe that the person they have in custody is mentally retarded, there should be no interrogation unless an attorney is present.

YOUTHFUL RETARDED OFFENDERS

On February 2, 1966, a report of the Attorney General's Advisory Committee on Juvenile Crime, Commonwealth of Massachusetts, noted that 50% of the 72 district courts have dispositional problems for retarded children coming before the courts. State training schools are reporting an influx of youths who are both delinquent and retarded. This trend is disturbing in two ways. State facilities for retarded youth

are severely lacking. Adequate educational training is difficult to develop in settings where dull children are frequently used as foils by more intelligent and aggressive delinquents.

The report points out that retarded youths who were initially prompted by their friends to commit acts of vandalism are subjects of the same exploitation after they are in training schools. In addition, the report suggests that a legislative commission examine the problem from all points including types of new facilities for retarded delinquents and the cost of such a program. The wayward or delinquent child between the ages of 7–17 who is a subject under Chapter 123, Section 100 — pretrial observation in a state mental hospital — should be included in this study. At present, most pretrial observation of 7–17 year olds are done at the Gaebler Unit of Metropolitan State Hospital. Persons over 17 are sent to the regular state hospitals in the Commonwealth.

PREVENTING RETARDATION

RECOMMENDATIONS

BIOLOGICAL AND MEDICAL FACTORS

EARLY PRENATAL CARE

201. Prenatal and maternal health services for high risk patients should continue to be vigorously augmented by the Department of Public Health. Maximum utilization should be made of federal funds available under the 1963 amendments to the Social Security Act. Collaborating with the Department of Public Welfare, local health departments, welfare boards, and concerned voluntary agencies, the Department of Public Health should strive to develop new methods of locating women early in pregnancy.

202. Each clinic providing prenatal care should publish regularly a frequency distribution of the patients delivered on their services according to the month in which the first visit during pregnancy was made as a basis for self study and improvement of services.

203. Two items, "date of first visit during pregnancy" and "date of last menstrual period," should be added to the certificate of live birth The Division of Health Statistics should utilize these items periodically to tabulate the proportion of patients in the Commonwealth receiving late or no prenatal care and to evaluate low birth weight.

204. Postgraduate teaching programs on prenatal care conducted by the Committee on Maternal Welfare of the Massachusetts Medical Society and the departments of obstetrics of the teaching hospitals should continue to be encouraged and supported by the Division of Maternal and Child Health of the Massachusetts Department of Public Health.

STANDARDS FOR MATERNITY AND NEWBORN CARE

205. A code of regulations which reflect the highest known standards and procedures for hospital maternity and newborn services should be adopted by the Public Health Council. This code should be prepared by the Division of Maternal and Child Health with the aid of expert advice.

206. Minimum standards for maternity care by physicians should be adopted through the cooperative efforts of the Committee on Maternal Welfare of the Massachusetts Medical Society; the Massachusetts Chapter of the American Academy of Pediatrics; Committee on Fetus and Newborn; the Massachusetts Section of the American College of Obstetrics and Gynecology; the Chiefs of Obstetrical Services of the larger hospitals providing obstetrical services in the Commonwealth; and the Commissioner of Public Health.

207. Hospitals should arrange for supervision and follow up evaluations of children born to mothers with complications of their pregnancies.

DETECTION OF INBORN ERRORS OF METABOLISM

208. Funds should be provided to enable the Division of Diagnostic Laboratories to conduct research on feasible screening methods for the detection of inborn errors of metabolism, including large scale pilot trials to determine the usefulness of screening techniques.

GENETICS COUNSELLING

209. Experimental professional education programs in genetics counselling should be developed by the Massachusetts Department of Public Health.

210. Genetics counselling services should be encouraged and supported by the Department of Public Health so that such services, wherever established, will be available to all regardless of ability to pay. A roster of physicians and clinics qualified to furnish genetics counselling should be made available to couples who desire family planning services.

211. Stipends and training opportunities to encourage physicians to specialize in clinical genetics should be provided by the Massachusetts Department of Public Health and the U. S. Public Health Service.

STANDARDS FOR EXPOSURE TO IONIZING RADIATION

212. The program for inspection of sources of ionizing radiation should be accelerated by the Department of Public Health. Appropriations for this program should be increased to permit the appointment of two additional inspectors and a radiation physicist. A joint committee of the Massachusetts Medical Society, the Society of Radiologists and other professional societies concerned with control of radiation hazards should determine whether the principles expressed in the *Manual of Standards in Obstetric and Gynecological Practice* of the American College of Obstetrics and Gynecology are fully in effect in Massachusetts.

213. Licensure rules for hospitals in Massachusetts should be reviewed by the Public Health Council to define the term "competent radiologist." Standards of training necessary for x-ray technicians should also be considered by the Council.

SELF MEDICATION

214. A program of health education designed to promote professional and public awareness of the risks of self medication by women in the childbearing age should be undertaken by the Department of Public Health. The School Health Council and the Board of Higher Education should determine whether education in schools and colleges regarding self medication is satisfactory and report their findings to the Massachusetts Department of Education.

REGULATION OF UNSOLICITED DRUG SAMPLES

215. Distribution of unsolicited drug samples, which may be injurious to the user, should be curtailed through the strict enforcement of Chapter 270, Section 3 of the General Laws, regulating the distribution of certain drugs, and through the Department of Public Health investigation of the proper disposal of drug samples. The Massachusetts Medical Society should promote professional awareness of the problem.

TEST FOR RUBELLA IMMUNITY

216. A research project to compare the validity and applicability of the various techniques used to test for immunity to rubella (German measles) infection should be encouraged and supported by the Department of Public Health. When a standard test is available, the Division of Diagnostic Laboratories should establish a regular service for the determination of rubella immunity in pregnant women.

COUNSELLING ON RISKS OF CONGENITAL ANOMALIES

217. Upon confirmed diagnosis of rubella, physicians should provide counselling which includes information sufficient for couples to make an independent decision on whether to request therapeutic abortion.

STATISTICS ON THERAPEUTIC ABORTION NEEDED

218. Statistics on therapeutic abortion in the hospitals of Massachusetts should be collected and analyzed by the Division of Health Statistics of the Department of Public Health.

MODEL LAW ON JUSTIFIABLE ABORTION

219. The model law on justifiable abortion proposed by the American Law Institute should be enacted by the Legislature. Under this law, on the request of the family, a licensed physician can terminate a pregnancy for reasons related to the fetus, as well as reasons related to the life and health of the mother.

EXTENSION OF MEASLE VACCINATION PROGRAM

220. Additional measles vaccine should be purchased by the Department of Public Health to extend protection to older children, as well as to infants.*

DEVELOPMENT OF HEMOPHILUS INFLUENZAE VACCINE

221. Funds should be provided to the Department of Public Health to finance the development of a vaccine against hemophilus influenzae. Provision should be made for extended testing before routine use.

REVIEW OF CHILD ABUSE LAW

222. The Division of Child Guardianship should review and evaluate its experience in the administration of child abuse cases reported under Chapter 119, Section 39A of the General Laws.

AUTOMOBILE SAFETY DEVICES

223. The Massachusetts Safety Council should undertake the responsibility for disseminating standards which have been developed for restraining devices for infants and children in automobiles. Steps to make these restraining devices available to the public on a non-profit basis should also be undertaken.

PREVENTION OF LEAD POISONING

224. Physicians and child health clinic staffs should inquire repeatedly during the course of child health supervision as to whether the child has been eating paint or chewing plaster to determine if there is basis for taking a blood sample for blood lead determination.

225. Routine examinations of blood and urine samples obtained by local health departments from children living in housing presenting a high risk of lead poisoning should be conducted by the Division of Diagnostic Laboratories of the Department of Public Health. In addition, the Department of Public Health, in cooperation with state and local agencies concerned with improved housing conditions, should work toward the elimination of the danger of lead poisoning from paint in substandard dwellings.

CHEMICAL INJURY

226. To minimize the dangers to children from toxic chemical products, an educational and appropriate warning campaign should be supported by the Department of Public Health with the cooperation of Poison Control Centers.

MULTIPLE HANDICAPS

227. A concerted effort to study and develop techniques of diagnosis, training and teaching of children whose retardation is associated with other handicapping conditions should be undertaken by the Departments of Mental Health, Public Health and Education. This cooperative effort should include a review of the effectiveness of the current law requiring complete physical and psychological evaluation of children for placement in special classes and a survey to determine the extent to which needed services are lacking.

*This program was implemented by the Massachusetts Department of Public Health beginning September 1966.

SOCIAL AND BEHAVIORAL FACTORS

PRESCHOOL PROGRAMS

PRESCHOOL ENRICHMENT PROGRAMS IN HIGH RISK AREAS

228. Enrichment programs should be established for preschool children in areas of high socioeconomic need by all public and nonprofit school systems throughout the Commonwealth.

In addition, 10 pilot preschool day care enrichment centers should be established in areas of high socioeconomic need by public and voluntary health and welfare agencies.

STATEWIDE STANDARDS

229. Standards for preschool enrichment programs, as set forth in Chapter 111, Sections 58 to 62 of the General Laws, should be fully implemented for all those programs falling within the scope of the statute. For those agencies not now covered, as set forth by Section 58, comparable standards should be required by relevant supervising agencies.

STATEWIDE STIMULATION AND EVALUATION

230. Preschool enrichment programs for high risk areas should be stimulated and evaluated by the newly established Health and Welfare Commission if such Commission broadens its mandate to include for this function the Department of Education and the Commonwealth Service Corps. If the broadening of the Commission does not transpire, another appropriate interdepartmental mechanism should be established for this purpose.

Evaluation should include methods for determining to what extent programs reach intended populations as well as analyses of the health, education and welfare components of such programs.

PARTIAL AND FULL DAY PROGRAMS

231. In addition to partial day preschool enrichment programs, additional full day programs should be established, especially for the children of full time working mothers.

FUNDING SUPPORT

232. Preschool enrichment programs should take full advantage of federal and other public and voluntary funds to support continued operation.

EARLY PRIMARY GRADE COMPENSATORY PROGRAMS

SUPPLEMENTAL EDUCATION

233. Children from high risk socioeconomic populations should receive supplemental early primary grade education from local school systems.

READING EMPHASIS

234. Since reading is a basic skill required for further education, a primary goal of supplemental education should aim to teach appropriate reading skills in order to assure, to the extent possible, that all children learn to read at least at a third grade level before they enter fourth grade.

STATE GUIDELINES AND CONSULTATION

235. The state Department of Education should prepare guidelines and provide consultation to school systems encouraging the development of new methods and techniques and built-in evaluation procedures for early primary grade education.

236. The state Department of Education should publish a progress report no less frequently than every two years, on progress of local early primary grade enrichment programs.

FUNDING HELP

237. The state Department of Education should continue to assist and encourage local school systems in actively procuring funds from programs such as The Federal Elementary and Secondary School Act 1965 (Title 1, 3, 4) for developing new methods and techniques.

STAFFING HELP

238. Four additional supervisory positions should be provided the state Department of Education to review projects, give advice and provide other field sources for school programs with disadvantaged populations.

The state Department of Education should establish, under Title 1, a new position of research consultant to provide proposal formulation and implementation leadership and consultation to local school programs and cooperative school-university programs under Title 4.

EVALUATION

239. School systems utilizing new methods and techniques should include a systematic evaluation of the effects of alternative programs in cooperation with the state Department of Education.

REFORMULATION OF SERVICES

EXTEND SERVICES OF ESTABLISHED AGENCIES

240. Established health, education and welfare agencies which provide the bulk of human services to the disadvantaged in the Commonwealth should be encouraged to more effectively extend services to populations of highest risk and greatest need.

STATE LEVEL COORDINATION

241. The Health and Welfare Commission under an expanded mandate to include the Department of Education and the Commonwealth Service Corps should stimulate state and local agencies to develop extended service demonstrations and build in evaluation procedures and to assist in procuring funds.

COMPREHENSIVE SCHOOL AND HOSPITAL PROGRAMS

242. Because of their pivotal influence, schools and hospitals should be especially encouraged to experiment with techniques and methods which reduce the fragmentation of services to high risk populations and develop more comprehensive approaches to total health, education and welfare needs.

AN OVERVIEW

Conditions which spawn many other health, welfare and social problems are, to a large extent, the same ones responsible for some forms of retardation.

These conditions may be divided into biomedical and socioeconomic preventive factors which must be addressed at the earliest stages in the life cycle. Although the biomedical and socioeconomic factors are considered separately in this section, realistically they are intrinsic parts of each other. Organic and nonorganic aspects constantly impinge on each other and the relation has been noted where appropriate.

In considering biological and medical prevention, expectations for new preventive possibilities must be tempered by the realization of the complexity of the causes of retardation. However, significant progress has been made through more widespread effective application of some of our present knowledge. For example, this year between two and three hundred infants in the United States will suffer severe retardation due to phenylketonuria (PKU), a condition which is clearly preventable. The manner in which Massachusetts has developed techniques to prevent PKU is an excellent example for the rest of the nation. Yet, the point remains that there are many other conditions associated with retardation which are also preventable, but sufficient attention has not been devoted to developing effective preventive techniques. Possibilities for achieving a higher degree of success through application of existing knowledge are clearly evident.

Prevention of retardation involves not only consideration of the biomedical aspects but also consideration of the social and behavioral factors which affect those individuals who function at a retarded level even though there may be no evident biological basis for the retardation.

Most individuals eventually identified as functioning at the retarded level fall into the above category. Social and behavioral factors associated with preventing these risks of retardation are even more complex than the biological factors, and comprise the second section of this report.

Two criteria were established for the inclusion of recommendations. Firstly, there had to be actual knowledge or a strong presumption that the factors or proposed actions affected the risk of retardation. Secondly, these factors had to be capable of being dealt with within the existing resources of the Commonwealth or with new resources which could be developed. Taking these two considerations into account, recommendations were made with the view of promoting efforts to prevent retardation through the more effective application of existing and newly acquired knowledge.

A MEDICAL AND HEALTH APPROACH TO PREVENTION

EARLY PRENATAL CARE

Retardation is significantly higher in population groups where prenatal care is frequently inadequate, where complications in pregnancy are not identified and the rate of premature delivery is high. P.L. 88–156, "Maternal and Child Health and Mental Retardation Planning Amendments of 1963", provides for authorization for federal grants to meet up to 75% of the cost of projects for the provision of prenatal care to prospective mothers who are likely to have conditions associated with childbearing which increase the risk of retardation. To receive funds, the state health department must determine which groups will not receive necessary care because of their low income status or other reasons. The Department of Public Health is responsible for the submission of grant applications unless it delegates this responsibility to a local health department on the basis of a satisfactory local plan. The Department of Public Health has developed a proposed project for Boston. Springfield and other communities are working on plans to meet federal criteria. Efforts to make maximum use of federal funds to increase maternal and child health services for high risk patients in the Commonwealth must be continued.

A significant proportion of expectant mothers, particularly among lower socioeconomic groups, receive little or no prenatal care. Studies on the increase of the number of births with late or no prenatal care in New York, Baltimore and elsewhere, indicate that this is becoming a serious problem, especially in large urban centers. Information as to the extent of this problem in the major cities of Massachusetts is not available and therefore should be secured and reported both by the Division of Health Statistics and individual clinics. Information gathered by the Division of Health Statistics could be used to provide periodic tabulation of the proportion of patients receiving late or no prenatal care by geographic area, population subgroups, etc., while information compiled by each clinic could serve as a basis for self study and improvement of services. Publication of these statistics will also have the beneficial effect of emphasizing the importance of early prenatal care.

STANDARDS FOR MATERNITY AND NEWBORN CARE

All hospitals are required to meet minimum standards for hospital licensure. However, to minimize the risk of retardation in the perinatal period, specific standards as to physical facilities, medical staff, nursing staff, laboratory and other maternity services should be adopted. Such standards should be similar or more stringent than those expressed in Article 41 of the New York City Health Code. Provisions should insure that each hospital maintaining maternity and newborn service is staffed and equipped to utilize known procedures for the prevention of prenatal and neonatal defects, and to deal efficiently with maternal complications of pregnancy. Illustrative of the type of standard needed is the provision for a

properly operated blood bank. Likewise, standards for facilities and qualified staff to insure early diagnosis and prompt exchange transfusions would serve to reduce brain damage and accompanying retardation resulting from Rh or ABO incompatibility and other types of hyperbilirubmemia.

Hospitals should be helped to meet new standards of maternity and newborn care. However, if after receiving technical and financial assistance, a hospital is unable to conform to the standards, approval and license for maternity care should be withheld.

In addition to promulgation of hospital standards, adoption of minimum standards of good practice in maternity and newborn care by obstetricians throughout the Commonwealth would serve to maintain the quality of prenatal care and reduce the frequency of subsequent complications.

As knowledge about the effects of certain complications before, at and after birth is incomplete, specific arrangements for careful and continued supervision of infants with birth complications is important.

DETECTION OF INBORN ERRORS OF METABOLISM

The Division of Maternal and Child Health, and the Diagnostic Laboratories of the Department of Public Health are to be congratulated upon the initiative, thoroughness, and excellent organization of the screening detection of phenylketonuria (PKU). Massachusetts was, perhaps, the very first state to achieve virtually 100% coverage of all newborn babies and to institute a clinic program for the assessment and care of children found as suspect cases on the screening procedure. This excellent program could take on an added utility if physicians would submit filter paper blood specimens from older children who are not prospering, and from expectant mothers who are retarded, or in those family there has been a known or suspected case of PKU.

Despite the highly successful Phenylketonuria Detection Program of the Diagnostic Laboratories and the Division of Maternal and Child Health, sufficient funds have not been made available to allow for the development of screening methods for the detection of other inborn errors of metabolism. The wisdom of investing in research to extend the successful techniques of the PKU program to other metabolic disorders becomes evident upon reviewing the results of the PKU program. Annual cost for the detection program covering 115,000 births a year, together with the cost of the assessment program, the clinic study, the management of the known cases, and the supply of the Lofenalac milk is about $80,000. Institutional care for the lifetime of one severely retarded child is estimated at approximately $100,000. If the 36 cases prevented through the PKU program had gone on to severe retardation and institutionalization, the cost of lifetime care to the Commonwealth would have been more than three and a half million dollars. Economics aside, the realization of the prevention of retardation, as illustrated by the PKU program, is in itself reason enough to augment research efforts in this area.

Funds for detecting further disorders must be sufficient to finance wide scale pilot trials. Large scale field trials are necessary, not only to determine the accuracy and usefulness of given screening techniques, but also to serve as effective demonstrations to help motivate their wide use and to evaluate possible treatment.

GENETICS COUNSELLING

Although a significant number of instances of retardation can be attributed to known genetic factors, genetics counselling services are not readily available.

The application of genetics research to the prediction of retardation has not received sufficient attention. In addition to Mongolism, which is one of the most frequent of prenatally determined conditions, genetically produced conditions such as phenylketonuria, galactosemia, maple syrup urine disease, and many other inborn errors of metabolism illustrate the need for available genetics counselling. Once an individual with genetically determined retardation is identified within a family by intensive study of the family history, clinical examination and laboratory tests, the probability of recurrence in future members can frequently be determined. Occurrence of further affected individuals in the family may be reduced by voluntary limitation of pregnancies by couples who are aware of the risks. Genetics counselling includes providing information of the risk and discussing this information with the couple concerned, relating it to family beliefs, religious convictions and other individual considerations.

The recent addition of Section 21A to Chapter 272 of the General Laws has made possible the development of a social environment in which genetics counselling can contribute to the prevention of retardation. Section 21A, in substance, provides that physicians may prescribe and pharmacists may furnish drugs or articles intended for the prevention of pregnancy. Under the law private nonprofit or public health or welfare agencies may furnish information as to where professional advice regarding such drugs or articles may be obtained. Now informed public attitudes, which provide the foundation for successful genetics counselling services, can be fostered through experimental education programs and a review of the teaching of genetic information in our public and private schools.

STANDARDS FOR EXPOSURE TO IONIZING RADIATION

Exposure to ionizing radiation during the first three months of pregnancy may produce defects and increase the risk of retardation. Risks resulting from diagnostic x-ray can be reduced by assuring that all radiological personnel and equipment meet accepted standards. This can be achieved through a review of the adequacy of present standards and provisions to insure enforcement of standards. The Bureau of Hospital Facilities is conducting a radiation protection survey of diagnostic x-ray equipment. However, the great increase in the use of medical x-rays plus the lack of sufficient inspection personnel combine to produce the need for an accelerated effort.

Current efforts by the Department of Public Health and the Massachusetts Medical Society to identify the users of ionizing radiation are to be warmly commended.

EFFECT OF DRUGS

Certain drugs, although not necessarily harmful to adults or children, may have a deleterious effect on the developing fetus, especially if used during the first three months of pregnancy.

Profound emphasis was given to this problem by the recent thalidomide tragedy.

The U. S. Food and Drug Administration and the National Institute of Child Health and Human Development are responsible for developing procedures for evaluation of drugs from the standpoint of effects on the fetus and newborn infant. Their findings are not, however, matters of common knowledge. Therefore, much should be done at the state level to reduce the risk of retardation resulting from indiscriminate use of drugs, through a well organized program of health education. Health education efforts should be directed to

physicians, pharmacists and school officials, as well as to the general public. This multifaceted program is necessary to reach all women of childbearing age. During the period of maximum risk many women, not aware of their pregnancy, take drugs without suspecting the dangers involved and without the direct supervision of a physician. The most appropriate vehicles for influencing attitudes on self-medication are the health education courses in our public and private schools. If these courses do not now provide for suitable instruction in this area, steps should be taken to rectify the situation.

Control of mailed unsolicited drug samples to physicians is within the jurisdiction of the federal authorities. Nevertheless, the Department of Public Health can diminish the resultant risks by focusing the attention of the medical community on the dangers of their easy availability, and by promoting strict enforcement of Chapter 270, Section 3 of the General Laws regulating distribution of drugs and medicines which may be harmful. The Massachusetts Medical Society should also actively support this effort.

TEST FOR RUBELLA IMMUNITY

Rubella (German measles) infection of a mother in the first three months of pregnancy may cause a variety of severe anomalies in the fetus even though the mother herself has minimal or no symptoms of illness. Establishment of her immunity from a prior infection or confirmation of a current, even asymptomatic, infection is most important.

As yet, there is no universally accepted test to determine immunity to rubella infection. Fluorescent antibody techniques seem most promising at the moment. Determination of the most satisfactory techniques would make possible statewide service in detection of rubella immunity where indicated and diagnosis of the result of exposure. The impact of other viral infections which may cause fetal damage should also be explored.

INDIVIDUALIZED COUNSELLING AS TO RISKS OF CONGENITAL ANOMALIES

Patients who had a diagnosis of rubella or other conditions increasing the possibility of fetal damage during the first trimester of pregnancy, are sometimes not being advised as to the risk of congenital anomalies.

Because of the high risk of a defective fetus in cases of rubella and other damaging factors during the first three months, the couple concerned may consider requesting a therapeutic abortion. The decision of the couple should be made on the basis of sound advice as to the risk and only after a review of all relevant personal factors. Statistics collected in other localities, showing that therapeutic abortions are four times as frequent among private patients as among ward service patients, indicate that desired counselling and services may not be available to all patients on an equal basis. Since we do not know to what extent this situation exists in Massachusetts, comparable statistics should be gathered and analyzed.

Present law relating to termination of pregnancy makes no provision for justifiable abortion in cases of substantial risk of a gravely defective fetus. This omission in the law may inhibit a couple from obtaining a therapeutic abortion when all personal and medical considerations would otherwise favor the operation. Enactment of the American Law Institute's model law would remove existing legal obstacles to a free and independent decision based on all the facts of the individual situation. The 1962 draft of the model penal code, Section 230.2 provides that "A licensed physician is justified in terminating a pregnancy if he believes there is a substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother, or that the child would be born with grave physical or mental defect. . . . Justifiable abortion shall be performed only in a licensed hospital except in case of emergency when hospital facilities are unavailable."

NEED FOR VACCINES

Infections of the central nervous system, accompanied by retardation, may result from infectious childhood diseases which can be prevented through the development and use of vaccines.

Measles presents an example of a common infectious childhood disease which is occasionally complicated by encephalitis and a severe degree of retardation. Effective measles vaccine has been developed and is in current use by private physicians. The Department of Public Health is to be commended for making the vaccine widely available to clinics and physicians for innoculations to children 9 months to 12 years of age.

The Division of Biologic Laboratories of the Department of Public Health has considered the feasibility of developing a vaccine against hemophilus influenzae meningitis. This form of meningitis occurs primarily in young infants and antibiotic therapy has never been wholly satisfactory. It is estimated that there are 5,000 cases per year in the United States. About 10% or 500 die and several times this number suffer brain damage. On this basis, there are approximately 10 deaths per year from this type of meningitis in Massachusetts and an additional 20 or 30 children per year are permanently damaged with neurological defects or mental injury or both. Thus, hemophilus influenzae meningitis appears now to be an important cause of central nervous system damage. It is hoped that a vaccine could be combined with the routine Diphtheria Pertussis Tetanus preparation given regularly to young children. There is good reason to believe that an effective vaccine could be prepared. However, the state laboratory has not been able to make any significant progress in its development because the necessary research staff and funds have not been available.

REVIEW OF THE CHILD ABUSE LAWS

Risk of brain damage from inflicted physical injury or parental neglect requires an increased effort to identify the "battered child" and to provide necessary social services and psychiatric help for the parents.

In Massachusetts, a physician with reasonable cause to believe that a child he is treating has been physically abused is required by law to report such injury to the Department of Public Welfare. The Division of Child Guardianship within the Department is responsible for following up these reports and assisting the child and his family. Child abuse statutes (G.L. c. 119, §39A, §39B) were enacted in 1964, and the Division of Child Guardianship has had just under two years to work under the law. (September 1964 to June 31, 1965 — 102 cases officially reported.) However, even at this early stage, a review of the Division of Child Guardianship program in terms of physician response and disposition of reported cases would be profitable.

Attention should be directed to the manner in which the physician has adapted to his new legally defined role. Despite legal immunity from liability for defamation, it is believed that physicians may be reluctant to consider the diagnosis of parental abuse. This is unfortunate, because the physician is in a good position to identify cases of child abuse and to anticipate situations in which there is a risk of inflicted physical injury.

Another aspect of child abuse cases which requires study involves the duration of placement. Some observations indicate that it may be desirable to separate the child from his parents beyond the time necessary for the child's physical recovery, so as to furnish the opportunity for psychiatric consultation and improvement of the family situation. More information is needed as to proper management of these cases.

AUTOMOBILE ACCIDENTS

A high percent of automobile accidents involving infants and children result in brain injuries to these youngsters.

Retardation due to head trauma from automobile accidents could be reduced through the establishment of national safety standards for automobile manufacturers. The Massachusetts Safety Council should disseminate standards for restraining devices for infants and children in automobiles and make these devices available to the public on a nonprofit basis. The regular use of proper restraining devices for protection of children riding in automobiles is only one example of the possibilities for prevention of retardation through the study and control of environmental factors associated with childhood accidents.

CHEMICAL INJURY

Ingestion of toxic substances, especially lead in paints, may cause retardation.

While efforts have been made to assure elimination of lead from paints used for indoor surfaces, the danger of retardation due to ingestion of lead still continues to exist. To reduce this hazard, a cooperative effort is needed by the Department of Public Health and housing authorities of the state, cities and towns to formulate and enforce standards. Repeated inquiry to uncover whether children habitually eat paint or chew plaster is also necessary. New York and Baltimore have developed large scale programs to diagnose lead poisoning in children by routine blood-lead determination. The feasibility of establishing similar large scale projects in our urban areas should be seriously considered.

Current research studies at Massachusetts Institute of Technology concerning the cumulative effect on children of low dosages of lead, as in air pollution, are to be commended.

Related to the problem of lead poisoning is the danger of brain damage caused by toxic substances such as pesticides. Control of hazards in this area can be accomplished through the Department of Public Health regulatory authority and through programs of health education.

MULTIPLE HANDICAPS

Associated handicaps are quite common in retarded individuals. Especially frequent are cerebrally determined handicaps such as cerebral palsy, convulsive disorders, and speech, hearing and vision disorders. These handicaps may compound retardation, producing a double handicap.

Adequate treatment of all disabling conditions is essential to the total well being of the retarded. In the past, the needs of the multiply handicapped retardate have been neglected to the extent that an interdepartmental effort is required to improve the situation. In addition to developing methods of diagnosis and treatment and periodic evaluation, the departments concerned should conduct a survey to determine whether needed services are supplied and whether administrative practices serve to deny retarded individuals the care which is available to mentally normal physically handicapped persons. It should be recognized that the retarded person has a right to expect that the same diagnostic and treatment resources available to others will be open to him.

Secondary prevention in retardation through treatment of associated disabilities should be made with the view of bringing about satisfactory social adjustment, as well as lessening aggravation of existing mental deficiency.

A SOCIAL APPROACH TO EARLY PREVENTION WITH HIGH RISK POPULATIONS

Socioeconomic and environmental conditions such as poverty, slums and inferior education also contribute to underachievement associated with mild and other forms of nonorganically linked retardation.

The President's Panel on Mental Retardation reported the finding that an estimated three percent of the population or 5.4 million children and adults in the United States are afflicted with retardation. The largest group, approximately 2.6 percent of the total population or 4.7 million persons are considered mildly retarded. These individuals often become the problem members of our society, capable only of a marginal productive role.

Translating national statistics to local populations involves inherent limitations. However, since the statistics represent the only available national figures, they have been used to make the following tentative projections for Massachusetts:

- About 140,000 individuals might be classified as mildly retarded.
- Children who are mildly retarded are heavily concentrated among families with low incomes and poor education.
- More than one-half of the persons in the state categorized as living in poverty under criteria established by the Office of Economic Opportunity may be classified as mildly retarded during some stage in their lifetime.

Theoretical and empirical findings in the social and behavioral sciences point up the following considerations:

- The heavy prevalence of mild retardation in certain deprived population groups suggests that adverse social and economic factors may play a major causative role, although not yet fully delineated.
- Young people appear to be stunted intellectually during their childhood by being deprived of opportunities for learning intellectual skills, through childhood emotional disorders which interfere with learning or by obscure motivational factors. Evidence strongly suggests that the root causes of a substantial part of the problem of retardation are to be found in the social and economic conditions affecting individuals and families. Correction of these fundamental conditions is necessary to prevent retardation successfully on a truly significant scale.
- Target populations often live in the slums and are frequently members of minority groups. Often, mothers and children receive inadequate medical care, family disruption is common and individuals are inadequately motivated to acquire adequate education.

THE EARLY YEARS

Retardation literature sometimes reports that low achievement in school results from the presence of poor genetic stock (the so-called familial retardate). This argument overlooks the fact that unsuccessful parents create an environment

within which a child grows up. This environment provides a limited series of models by which the child comes to see the range and possibilities of behaviors available to him. The child's world acts to influence his behavior just as his genetic endowment sets limits on the range of behaviors which he can attain as possible goals.

The present day conception is that environmental factors or "social heredity" and the genetic transmission systems are inextricably interwoven. It is almost impossible to distinguish the separate effects. However, the social component must be conceived most broadly.

Environmental influence can create predisposing factors for poor physical health as well as poor behavioral outcomes of adulthood such as lowered levels of employability. Homes of high risk families tend to be crowded, have less space available for the child to do his school work and have an underlying atmosphere of anxiety about basic problems concerning money, food, clothing, shelter and legal involvements.

Based on their own experiences, low income parents frequently perceive fewer opportunities for advancement for their own children. Furthermore, they communicate these limited expectations to their children.

In a very real sense, the growing child's views of what is accessible to him and what should not even be considered within his realm of possibility is strongly influenced by the expressed attitudes of his parents and other adults.

A more detailed discussion of the relations among low achievement and socioeconomic, race and home factors has been prepared for the project.[1]

Poor social conditions have disastrous effects on the child from the moment of conception and are considered to have a progressively more deleterious effect. Therefore, emphasis must be directed toward early intervention by health, welfare and education service givers to prevent or reduce the consequences of poor social conditions.

PRESCHOOL PROGRAMS

Public and nonprofit schools and health and welfare agencies should take full advantage of opportunities provided by the federal government to sponsor summer and year around preschool enrichment programs in areas of high socioeconomic need in the Commonwealth. In addition, 10 pilot preschool day care enrichment centers should be established by public and voluntary health and welfare agencies.

Evaluative research, built in at the outset of preschool programs, should aim to discover what facets of the program are most responsible for:

- Establishing patterns and expectations of success for the child which will create a climate of confidence for his future learning effort.
- Improving the child's mental processes and skills.
- Improving the child's physical health.

The decision of President Johnson to place the federally supported preschool program for poor children, Project Head Start, on a year around status is a sound move. However, there should be enough time to "tool-up", to hire staff, to prepare equipment, material and facilities and to establish necessary relations with cooperating health and social agency officials and parents. More efforts should be directed to involve the most needy families and to recruit the youngsters most in need of the experience. Provision for critically analyzing the results of previous efforts should prove of benefit.

Although the Head Start program has been justified initially on the grounds of the need for an immediate and massive intervention, coordination of efforts at both the state and local levels will be necessary to insure that standards for this program and other preschool enrichment programs are developed which eliminate the problems described above.

State level coordination is necessary to maintain standards and to stimulate requests because federally sponsored Head Start programs are initiated locally. Programs emanating locally have the advantage of generating local identification, enthusiasm and flexible structural arrangements. However, the Commonwealth cannot be sure that areas that most need preschool programs will necessarily initiate service requests.

Adequate coverage is also important on the local level. Sub areas within towns or cities also should receive these services and should also be locally coordinated. Local school committees, councils of social agencies, local welfare and health departments and community action programs (anti-poverty organizations) should collaborate in performing functions similar to the state on the local level.

Should these programs prove to be successful in decreasing the risk of school failure among the children from poor socioeconomic backgrounds, efforts should be made to make these programs available to all needy children in the cities and towns of the Commonwealth.

The similarity in goals and suggested procedures for the Office of Economic Opportunity sponsored Head Start efforts and the more traditional day care programs emanating from public and voluntary health and welfare auspices is striking. Office of Economic Opportunity programs stress the need for a comprehensive approach, one which "requires extensive activities in the fields of health, social services and education."[2] A set of guidelines from a Massachusetts day care program stipulates that day care must be seen as "a partnership of education, social welfare, and the health professions in providing, first, the optimum environment for the physical, emotional, social and intellectual growth of the child to the maximum of his capacity . . . "[3]

A major impetus for the development of day care centers in the United States has been the increased numbers of mothers of young children who have joined the labor force. (Nationwide, approximately 15 million children are in homes with working mothers.)

The Office of Economic Opportunity and the Child Welfare League of America stress the need for educational, physical and mental health goals for their preschool programs. The Commonwealth should attempt to stimulate the development of all preschool enrichment programs which meet recommended standards. Under this proposal, the question of the source or auspice of the service (school system, welfare or health agency) or the label of the service (Head Start or Day Care) should not impede the development of preschool enrichment programs to all high risk areas of the Commonwealth.

Educational components of the program should include varied experiences to develop conceptual and language competence, to allow positive interaction with authority figures such as policemen, teachers, health and welfare workers and to create opportunities for a consistent warm relation with children and adults. The daily program should have continuity and flexibility and should be related to the progressive developmental requirements of each child. Allowances should be made for the need for some children to have relative

[1]Material on this subject by James Teele, Ph.D. available on request.

[2]Dr. Robert Cooke, Chairman Planning Committee, Project Head Start, "Improving the Opportunities and Achievements of the Children of the Poor" (mimeographed).

[3]Associated Day Care Services of Metropolitan Boston, Guidelines for the Operation of Day Care Centers, March 1965 (mimeographed).

freedom in their routine activities and for others who need to have more structured experiences. Regularity in the daily routines should provide the children with a sense of stability and continuity, but there should be changes in the rhythm of the day. Independence and self-sufficiency should be cultivated to allow the child to gain a sense of mastery over his environment and competence in meeting the challenge of real tasks. Group play as well as solitary activities should be encouraged, and a balance between indoor and outdoor curriculum maintained. The child's experiences in his family group should be related to those in the day care group. Most importantly, the program should allow for individualization in accordance with each child's developmental level, capacities, special needs or problems, and experiences at home and in his neighborhood.

Active parent participation should be built into the program. Homemaking, counselling and other social services should be made available. Volunteers of all ages, ethnic groups and backgrounds should be encouraged to contribute to local preschool enrichment programs.

A full gamut of services to protect health and to promote good health should be made available, including comprehensive medical assessments, dental examinations and mental hygiene screening. These health services would discover strengths to build upon and special problems in social, emotional and intellectual functioning.

Evaluation of all the above programs should be continuous to achieve maximum benefits from those services which work and to discard those program components which don't prove fruitful.

Approximately 33,000 Massachusetts children currently participate in preschool programs according to a Day Care Study nearing completion conducted by the Massachusetts Committee on Children and Youth. Available information indicates that a very small proportion of these youngsters are from high risk families. During the summer of 1965, approximately 8,500 Massachusetts children were enrolled and attended Head Start programs or about a tenth of those in the state eligible under criteria established by the Office of Economic Opportunity.

EARLY PRIMARY GRADE COMPENSATORY EDUCATION

A supplemental or compensatory education program must be instituted early in the child's school career. Children should learn basic school skills quickly and successfully. This is critical since early achievement by the child seems to influence the parent to view the child as a good student and the child to view himself similarly. In addition, early and successful school achievement may serve to build a sense of confidence in the child which may act as a stimulus for continuing achievement.

All children should leave the primary grades with satisfactory and workable skills, particularly in reading. Reading is basic to all later schooling and must become the focus of the school's energies. Supplemental educational experiences should be planned for children from culturally disadvantaged backgrounds to assure that they do not become classified as retarded children because of their failure to achieve satisfactorily by the third or fourth grade.

A major goal of a program of compensatory education should aim at focusing efforts to achieve the goal of successfully teaching children to read before they enter fourth grade. Students should be able to master third grade level reading with competency and interest. This would require a sight reading vocabulary of at least 500 words, the ability to read primary textbooks with fluency and interest and the ability to "attack" unknown words (phonic skill).

This goal will require experimentation with ungraded classes, maximum use of preschool classes, fewer students in each class, and more concentrated assistance from an increased number of remedial reading specialists. Programs have to be logically integrated into the child's primary grade experiences to develop preventive measures to forestall the possibility of a poor start in school. The state Department of Education should prepare guidelines and consultation to local school systems stimulating experimental methods and techniques of early primary grade education.

Federal monies provided by the Elementary and Secondary Education Act (Titles 1, 3, 4) should be sought by local school systems with the assistance of the state Department of Education to initiate early primary grade compensatory education innovations and action research. These programs should include systematic evaluation of the effects of various kinds of alternative programs aimed at the child who enters school but is slow in responding during the primary grades. High risk children frequently see the school program and the school curriculum as irrelevant to their own interests, needs and values. New innovative curricula must be developed to stimulate these children and build up their sense of involvement and desire for a sound school education during the early school years. Experts say that the school dropout is made by the age of 11 (or grade five). This is also a critical period for the child who eventually is classified as retarded by the school system.

In fiscal 1966, 195 cities and towns were included in school districts which received $16 million in Title I funds. To assist these school districts and additional school districts eligible under this program, additional supervisory positions are urgently needed by the Department of Education. Staff in these new positions will be used to review projects, provide consultation and offer field service for school services to disadvantaged populations. Additionally, a research consultant should be provided to the Department to give leadership and to help local school programs and school-university programs to acquire research and implementation assistance under Title IV.

A CHALLENGE TO OUR SERVICE NETWORKS: A REFORMULATION

In the past few years the federal government has initiated a great variety of social, economic and educational programs for disadvantaged populations.

Recent health, education and welfare programs focusing upon disadvantaged populations may be viewed as falling into two major categories:

- Fiscal devices such as the expansion of social security benefits, supplemental rent programs and expanded welfare payments. These devices are transfer payment programs which, although benevolent in intent, are by their nature impersonal. Under active discussion are other transfer payment programs such as the guaranteed annual wage and negative income tax. These programs are aimed at raising the floor of real income, especially for the lowest income groups of the population.
- In addition to some of the clearly mechanical impersonal programs, a whole series of measures are aimed at reaching specific populations with the intent of motivating and encouraging the needy to take advantage of the opportunities for self betterment. Job readiness and job training programs emanating from the Department of Labor; Job Corps, Head Start and Community Action

Programs from the Office of Economic Opportunity; job supplement programs from the Welfare Administration; and community mental health and retardation programs of the Public Health Service are examples of efforts offering advancement to disadvantaged persons. These programs are intended to bring public resources more in touch, in personal terms, with the alienated, the unattached and the unmotivated.

Proposals in the second category — those aimed at providing personal services to specific populations — include two forms of administrative models for carrying out their purposes. The first is the entry of new or ad hoc service structures which are separate from the traditional or established care giving agencies. The second model attempts to directly stimulate, and encourage innovation and change in the established agencies.

Established state and local agencies provide the bulk of human services to the disadvantaged in the Commonwealth. Efforts should be made to encourage these agencies to more effectively extend services to populations of highest risk and greatest need.

Given the weight of evidence that points to a relation between the family that grows up in an impoverished condition and the resultant psychological and social stresses, the question must be raised as to the manner in which the cycle of poverty can be broken. How can we minimize the impact of the poverty condition upon the child involuntarily born into this situation?

If answers had already been found, specific programs might be recommended, with specific procedures and price tags. Although clear pathways to success cannot be confidently predicted or recommended, major service agencies should begin to expend energy to establish strategies for more effectively serving high risk groups.

A Program of Action

Several models of service giving units should be sponsored and supported by the Commonwealth to have the responsibility for actually conducting or coordinating the delivery of an array of health, education and welfare services in areas of high social breakdown and social pathology.

The Health and Welfare Commission, in collaboration with the Departments of Public Welfare, Public Health, Mental Health, Education, Youth Service Board, Massachusetts Rehabilitation Commission and the Commonwealth Service Corps, should stimulate state and local agencies to develop demonstrations with built in evaluation procedures and to assist in procuring funds.

Federal funds could be sought from the National Institute of Mental Health, the Office of Economic Opportunity, the Office of Education and the Public Health Service to conduct demonstrations emphasizing some of the service approaches recommended in this report.

Possible Auspices for Demonstrations

The following auspices should be considered for demonstrations:

- Public or nonprofit schools.
- Health agencies such as teaching, general hospitals and/or a local public health department.
- Community mental health-retardation centers, mental hygiene clinic, state schools for the retarded, or state mental hospitals.
- The state or local department of welfare.
- Community welfare councils or voluntary agency affiliates.

A Network Approach

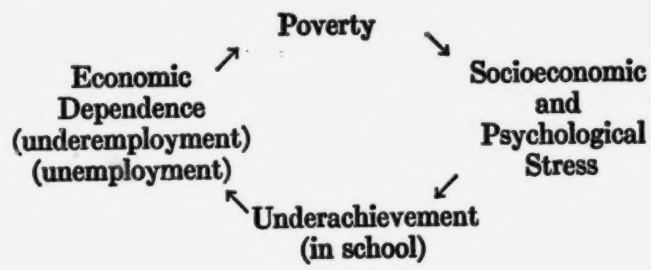
Based upon current information, a combination of environmental factors are assumed to be responsible for mild forms of retardation. Just as a combination of conditions are responsible for retardation, so a combination of measures will be necessary to alleviate many of the conditions associated with subnormal functioning.

No isolated or single program by itself has proven effective in counter balancing the complex interrelations of factors associated with high risk populations. Generally, studies dealing with educational or therapeutic measures have shown that the use of single, independent variables do not produce measurable results. Careful evaluation should be made of what services in combination reduce risks of subnormal functioning among vulnerable groups. Shotgun approaches at attempts to intervene in the lives of families trying to break the cycle of despondency and poverty may assuage the public guilt. They may even be beneficial to a proportion of the recipients. However, little knowledge is gained without careful evaluation. Effective programs must be isolated and studied to find out why they are effective. The relation between the factors associated with high risk and the processes ameliorating the contributing conditions must be uncovered.

Target Group

The population of concern should be the high risk child and his family. Criteria to be used for the determination of high risk could be based upon a composite index including the occupation of breadwinner, the educational level of parent with highest educational achievement and the income level of family. National projections utilized by the Office of Economic Opportunity suggest that one-fifth of the nation can be defined as living in substandard or impoverished circumstances. Therefore, families under the 20th percentile of the population in all three of the above indicators (occupational scale, educational achievement and income level) might be included as members of the target population.

Each demonstration agency should apply its knowledge and skills to aim at a goal at raising achievement levels in the early years with a view to economic self sufficiency in adulthood. Any and all points in the poverty cycle should be considered as instrumental in the total plan.



From this series of action research demonstration projects, several alternate models for intervention could be formulated, any one of which might usefully serve one community or another in the Commonwealth. Various service dispensing agencies should not be pitted against one another to evaluate which one is best. Rather, a series of alternate models for intervention should be developed. Each one will have started with a similar population base and seek to achieve similar goals.

Communities vary in the services which are most well developed and which can best serve as the focus for a coordinated effort to reach their needy citizens. In some communities, a general hospital exists and may provide such a focus; or an active network of family, welfare and child guidance services,

or the school. Then, alternate models of intervention should be formulated each starting from a different professional base reflecting differing central concerns, but all seeking to attain similar objectives. Each demonstration agency would formulate a plan of action using the resources of other agencies commonly found in a given community, or where lacking, establish new facilities to serve the particular needs of this kind of program.

Illustrations of the manner in which two agency prototype — the school and the inner city hospital — might extend services for a demonstration follow.

The School

The school system sees all the children in its district by law. Every family with children should come within its jurisdiction. Even lower class parents with extreme residential mobility accept the fact that "kids have to go to school." The school may well be the only formal institution with which a lower class child will come into contact.

Given the goals of the program, the educational system could conceptualize its role as an agency which can influence the achievement levels of its students and their later adult adjustment. A school system might select a school in a high risk area for a "special services" approach. The school would seek to involve many of the usual resources of a city or town in early detection procedures for children who seem to have problems — medical, emotional, familial. Programs of in-service training for teachers and a ready availability of appropriate consultants to do observational and diagnostic screening should be provided. Consultants would refer the children with suspected problems to appropriate facilities.

Various measures that could be carried out within the framework of the school might be planned. Experiences to help children avoid early failures might include small remedial therapeutic group instruction classes for low achieving children, an ungraded primary grade approach to classroom organization or other types of instruction that would be oriented toward compensatory educational enrichment.

Further, the school might develop an active effort to reach out to the families of children in need of various types of services as indicated from examinations and/or observations of the children in school. Social services and visiting public health nurses could be integrated into this effort. If unemployment or financial problems are uncovered in the family, contact with the appropriate community resources would be initiated. Many problems are evident within the school but the school has neither adequate facilities or sufficiently qualified personnel to deal with the situation.

School personnel should be sensitive and trained to detect a range of anticipated problems. For example, the child who chronically appears very disheveled or hungry or very tired might well be seen as coming from a family whose basic need may be some kind of homemaking assistance and/or guidance. Or maybe, on investigation, the mother is discovered to be ill and unable to care for the child, or negligent, or in some major way deficient in her performance, and a referral to a child welfare agency may be indicated.

Essentially, the school might be seen as a case finding agent. With the appropriate staff, schools would aggressively seek help from within their own range of specialties by providing services directly or by taking responsibility for the provision by others of a range of services to needy families who have been uncovered by the school staff.

If schools are to effectively extend and supplement their services in the suggested directions, serious attention must be given to the already overextended school personnel. Additional demands upon their time and energy could weaken the impact of any attempt to establish special or extended programming. Yet, merely adding additional staff for demonstrations, segregated from the rest of the school program without involving regular personnel would dilute the potential impact of the special program upon the regular established school personnel. A balance, therefore, must be struck between the introduction of new demonstration staff and freeing a portion of the time of regular staff for participation in the project.

Such an effort would be eligible for funding through the recently passed federal Elementary and Secondary Education Act.

The Hospital

Increasing emphasis has been placed by health professionals on the relation between socioeconomic status and ill health. Investigators have noted that merely a study of morbidity correlated to the usual socioeconomic factors indicate that a specific portion of the population is most in need of health and medical services. However, the precise influence of specific environmental factors still need to be pinpointed before preventive measures can really reduce the morbidity and mortality picture.

Public health efforts have produced some notable successful programs for the prevention of organically induced mental retardation. The pioneering phenylketonuria (PKU) screening program is an example of one such program in Massachusetts. It would be most desirable if health efforts were expanded from organic and physiological realms to include preventive methods to attack problems arising from economic, social and cultural factors.

At least two major reasons may be cited as contributing to the reluctance of health officials to develop a broader, more encompassing approach; one ideological and the other organizational.

Many health professionals have a traditional ideological reluctance to consider diverse social problems such as retardation as part of their responsibility. Part of this reluctance may stem from the fact that these social problems are not amenable to analysis and control through the application of traditional orderly methods and techniques of clinical research. For this reason, clinicians and health practitioners prefer adopting approaches to discover clinically observable organic brain damage.

Organizational considerations also contribute to the present situation. Although observers make reference to "a system of health services" there is in reality a highly fragmented pattern of agencies under various types of auspices. Very often these agencies provide exceedingly high quality health care to those persons or families who fall within their service orbit. However, these agencies take little responsibility for providing a coordinated spectrum of health services based on total patient needs. Nor do they as a matter of course reach out into the community to bring into their service orbit persons who may not have recognized their own health needs. Even when health agencies have made a systematic effort to provide total health care to patients on a coordinated basis, they have seldom gone outside the health field. Primary responsibility for correlating a broad range of social and welfare services on behalf of patients whose problems transcend the traditional boundaries of the health service field has not been assumed by health agencies.

One major component of the health service program should be the community health or human service center. A building should house the headquarters of the local health department and of other official and voluntary health agencies as well as related social welfare agencies. Individuals needing services would then be able to secure help at a central facility.

A second major component of the health-human service center should be a hospital with its related medical facilities. This medical center would provide a wide spectrum of services and facilities to meet the needs of various types of patients including intensive care, intermediate aid, self care, long term treatment and outpatient care facilities and training facilities for professional personnel.

A preliminary formulation of a comprehensive community health service center was spelled out in a 1963 policy statement of the American Public Health Association.[1] This statement may well furnish an appropriate model for the health disciplines in Massachusetts to use as a basis for a systematic effort to prevent some forms of underachievement and subnormal functioning. One or more general hospitals located in/or close to areas of high socioeconomic need should develop, as part of its general community role the services and facilities envisaged for the general hospital as a community health service center in the policy statement of the American Public Health Association. This would include acceptance of the obligation to "reach out" to other community resources to provide or take responsibility for the provision of the whole spectrum of help.

Services of all facilities in the center should be coordinated to insure that there are minimum barriers to continuity of care for patients or clients, to provide the maximum opportunity for interprofessional communication and to avoid duplication of ancillary, administrative, and housekeeping activities used in common by a number of health agencies.

Specific services to be provided by the community health service center should include:

- Disease control activities including immunization, epidemiological investigation, isolation and treatment of infectious cases and carriers, casefinding, by means of mass screening programs and periodic health examinations and follow up activities.
- Patient care services including diagnostic, therapeutic and restorative treatment provided through a combination of outpatient, day care and acute and long term inpatient facilities, as well as coordinated home care programs.
- Mental health services including prevention, evaluation, and treatment of emotional problems on both an inpatient and outpatient basis.
- Specific restorative services such as disability evaluation, physical therapy, practice in activities of daily living, vocational counselling and retraining and sheltered workshop services.
- Health services for mothers and children, including well infant and preschool care, school health programs, adolescent health services, prenatal care, family planning and genetic counselling services, parent education, and services for the diagnosis, evaluation and restoration of children with physical, mental and emotional disabilities.
- Dental health services with special emphasis on preventive and prophylactic services for children and on restoring dentition for the aged.
- Environmental control activities which should include efforts to influence all aspects of the physical and biological factors in the environment which may adversely affect health.
- Specialized supportive services encompassing nursing, laboratory, nutrition, and medical social services; comprehensive health education and information services; and social welfare services, which should be readily accessible to the center and its professional health staff.

Some of these components are developing, in embryo, in certain of Boston's teaching hospitals. These trends, wherever they exist, should be encouraged to the utmost.

The outlined concept of the community health center provides a framework, perhaps somewhat idealized, for a concerted effort by health organizations to reverse some of the invidious social effects of deprivation. A center's special virtue is that it places health services in a position to carry out a systematic effort in this direction.

Special stress must be given to the word "concerted". In many instances, various components have tended to provide service that has been either discontinuous, fragmented, or superficial — or all of these together. When services are provided in this manner, the individual service procedures have had little effect in overcoming the massive concentrated effects of deprivation, although the individual service may have been of good quality. Such programs have, in most instances, accomplished relatively little in breaking the family cycle of deprivation leading in some instances to mild forms of retardation.

If we can assume that the disadvantaged, as well as all other population groups, do seek to avoid ill health, then it is logical for a health center to reach out and treat the total child, adult or family and not merely concentrate on the health need bringing the person to the center.

Capsule Examples of Demonstrations Emanating From Other Sources

The community mental health program as projected by the Massachusetts Mental Health Planning Project will offer a combination of services which may include some not usually associated with traditional clinical programs in the past. High risk groups have not usually formed a major portion of the clients of mental hygiene clinics. Many clinic programs today tend to view the problems of clients from the perspective of psychotherapeutic goals, skills and knowledge. The addition of health, education, employment and welfare specialists would broaden the range of services rendered by these programs in serving high risk populations. Experimental methods could be attempted with environmental support services integrated into the mental health approach to the needy. Support from the National Institute of Mental Health or the Office of Economic Opportunity might be sought for such projects.

The model for a social welfare base might coincide with the conceptions and practices formulated by the multiservice centers sponsored by Action for Boston Community Development in Boston, and others springing up around the nation supported by the Office of Economic Opportunity and the Department of Health, Education and Welfare. These multiservice centers offer a broad spectrum of assistance. Their underlying premise is that services to the needy client must be proffered as close to the time of expressed need as possible and within easy reach of the client. The Roxbury Multiservice Center offers social casework, family counselling, legal and employment aid, homemaking guidance and mental health consultation. Staff persons work in the area surrounding the center and seek out those in need of service and help these persons to establish and maintain their contact with the center. Evaluation efforts are included as part of this center's activities. Data may be forthcoming shortly to indicate the effectiveness of this kind of effort.

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[1] "The Development of Community Health Service Centers: Present and Future", American Journal of Public Health 54: 140–146, Jan. 1964 (No. 1). (A Policy Statement adopted by the Governing Council of American Public Health Association at the 91st Annual Meeting, Kansas City, Mo., Nov. 10, 1963.)

Welfare networks such as the public welfare departments and the Division of Child Guardianship see children who present the highest probability for failure. A natural follow up question would ask how these networks might more actively seek to alter the fate of the young client. The national program for stimulating state and local welfare departments to provide additional social services to families receiving Aid to Families with Dependent Children and General Relief is still in a developmental stage. The thrust of the federal program is consistent with the task force proposal and might very likely be utilized for this purpose.

Total Service

Society attempts to reach children through the formal pathways of already existing state agencies and other voluntary service organizations. Current knowledge is lacking on which efforts combined in what package of services can most effectively break the poverty cycle.

Yet, agencies through demonstration programs should be encouraged to provide a variety of services to impoverished segments of the population which will be broader than the specialized skills currently provided by staff.

While the participating agencies may continue to provide their basic array of services, they will conceptualize their central role differently. If demonstration agencies will not directly provide the necessary additional services, they should be responsible for procuring them from other service givers.

Suggested demonstrations should seek to develop a broad range of models which communities can adapt to cope with the needs of high risk families. Recommendations for action could flow from a diversity of possible solutions to similar problems. One or more of the alternatives might prove most suitable for any given community.

STIMULATING RESEARCH

RECOMMENDATIONS

RESEARCH IN THE STATE DEPARTMENTS

243. Formal budgetary support for research in retardation should be at least 4% of each state department's expenditures for services to the retarded. These funds should be allocated for research without the diminution of funds budgeted for services.

244. Existing research or statistical units in each state department concerned with the retarded should be adequately staffed and financed. A part of the function of each research unit should be to conduct retardation research.

245. Funds for research consultation and statistical consultation should be budgeted for each of the state departments concerned with retardation.

246. Opportunity for and encouragement of research should be extended to all professional personnel who work with the retarded in state departments or state institutions.

STATE STIMULATION FOR RESEARCH

247. A State Retardation Research Fund should be established to provide researchers and professionals in the field of retardation with "seed money" for conducting preliminary research. This fund should have an initial total appropriation of $50,000. Responsibility for administering this fund and approving the recipients of grants should be vested in the Office of Retardation.

Priority should be given through the Office of Retardation to those areas of research not having adequate sources of support. At present, high priority for approval of such state grants should be given to research in social and behavioral areas, without the diminution of the present effort in the biomedical areas.

Encouragement should be given, by the Office of Retardation, to the development of objective and reproducible instruments to clarify the definition and measurement of retardation.

COORDINATION OF RESEARCH IN STATE DEPARTMENTS

248. Directors of research of each state department concerned with retardation should form a committee to meet regularly to discuss problems and issues and help determine priorities of retardation research. This committee should invite research personnel from the private sector, as it deems necessary. It should function in conjunction with the Office of Retardation.

RESEARCH IN THE STATE FACILITIES

249. All regional centers for the retarded should have research units. A study should be undertaken to determine how research units could be expanded at Paul A. Dever State School, Belchertown State School and Hathorne State School.

250. University and hospital researchers who utilize the state schools as a field laboratory should be expected to contribute a portion of their time and expertise for consultation or service.

CENTRAL RESEARCH MECHANISM

251. A mechanism for receiving and disbursing public and private research funds should be established within the state government. This mechanism should be responsive to the needs of individual investigators. The establishing of this mechanism may be a stimulus for revision in the present inflexible state fiscal, personnel and administrative procedures. Until such time as this mechanism is established private research corporations should be encouraged to continue to request, receive and disperse funds for financing research studies within the departments.

VITAL STATISTICS

252. A Bureau of Vital Health Statistics should be established in the Department of Public Health. This Bureau should maintain and operate a system of vital statistics for the state. Special attention should be given to the collection of material related to birth defects and retardation. This material should be recorded on a confidential section of the birth certificate, available to researchers.

STIMULATION IN THE PRIVATE SECTOR

253. The Office of Retardation should assist universities, medical schools, hospitals, laboratories and direct service agencies to seek federal and private funds for research support in retardation areas.

254. Universities and hospitals should be made aware of their increasing community responsibility to the retarded. These institutions should attempt to establish joint clinical and research programs and appointments with state departments and facilities serving the retarded.

255. The Office of Retardation should encourage private research foundations to support retardation research. These foundations should be encouraged to award grants for research projects and "seed money" for preliminary research.

COMMUNICATION OF RESEARCH

256. The Office of Retardation should establish and conduct a statewide semi-annual interdisciplinary symposium on retardation research. Professional personnel providing services to the retarded in both the public and private sectors should be invited to participate. The proceedings of these symposia should be published by the state.

CENTRALIZED RESEARCH FACILITIES

257. Efforts to centralize research facilities, including the development of data processing, to achieve efficient utilization of facilities by all departments should be continued by the Office of Administration and Finance.

SAFEGUARDS

258. A study should be implemented by the Office of Retardation to develop standards and safeguards which can be applied when retarded persons become subjects of research.

WHY RETARDATION RESEARCH?

Achievement of the goals of prevention and treatment of retardation requires extensive research in the biomedical, behavioral and social sciences. Much of the knowledge in these sciences ultimately may have relevance to retardation, but we are unable to predict what will be significant.

The problem of retardation is so wide in scope, so multi-faceted and so complex that research should not be limited to one orientation and therefore stifle creativity and originality. It is necessary to support all fields of research and to stimulate the communication of needs and results of research studies among investigators and service personnel working at all levels. There is a dire need for investigation in this state, as in others, into all areas related to retardation, by many different professions and agencies working with and for the retarded. Investigation by research and service personnel strengthens the service effort and permits recruitment of personnel of high capability.

CURRENT RESEARCH IN MASSACHUSETTS

Throughout the nation the federal government has been the leader in the support of retardation and related research fields. The major sponsoring sources within the Department of Health, Education and Welfare are the National Institutes of Child Health and Human Development, Neurological Diseases and Blindness and Mental Health; the Divisions of Hospital and Medical Facilities, Chronic Diseases, and Research Facilities and Resources; the Children's Bureau; the Vocational Rehabilitation Administration; and the Bureaus of Research, and Elementary and Secondary Education. In 1964, personnel working in Massachusetts received 6% of the total number of retardation grants issued by the Department of Health, Education and Welfare.

In 1965 this was reduced to 4.6% of the total number of grants. Even though the percentage of grants awarded to personnel in Massachusetts decreased, the number of projects and the total fiscal support increased. The number of grants increased from 45 to 59. Financial support increased from $3 million dollars to more than $4.8 million dollars. Although both the number and average allocation per grant increased in Massachusetts, the percentage of grants awarded to Massachusetts researchers has not kept pace with the national increase in retardation research and demonstration grants.

In 1962 the President's Panel on Mental Retardation recommended that high priority should be given to developing retardation research centers at strategically located universities and at institutions for the retarded. The recommendation stated that three centers should be established in the nation in the near future, with an ultimate goal of 10 centers. In 1965, two institutions in Massachusetts received approval to build two of the recommended 10 research centers. These research centers will be built at Walter E. Fernald State School and the Children's Hospital Medical Center.

STATE STIMULATION FOR RESEARCH

For Massachusetts to retain its present position as the state with the fourth largest number of retardation grants from the Department of Health, Education and Welfare, it will be necessary to stimulate investigators to conduct retardation research. Assistance from the proposed Office of Retardation could prove helpful in increasing the number of, and fiscal support for, retardation research.

Provision of "seed money" should be a proper state function for stimulating research. In its initial stage, an allocation of $50,000 should be a minimal starting point for a retardation research fund administered by a state interdepartmental agency, such as the Office of Retardation. Support should range from $500 to $2,500 per year. Within these limits 20 to 100 grants could be awarded the first year. When used for the necessary preliminary research work, "seed grants" could eventually lead to a federal grant, multiplying the initial investment on the average of about 50 times.

PRIORITIES IN THE ADMINISTRATION OF GRANTS

"Seed money" should be used to stimulate the type of retardation research that is most necessary. Judgment should be based on continuous appraisal of current research activities and financial support.

Behavioral and social sciences need the most stimulation through financial support at the present time. Biomedical retardation research receives five times as much financial support as does the behavioral and social science areas. The need for increased research by behavioral and social scientists is indicated by the accumulating evidence that a host of social, economic and environmental factors are correlated or associated to a high degree with the incidence and prevalence of mental retardation. Currently, research into the severely and profoundly retarded is to a large extent concentrated in biomedical research. There is a glaring lack of behavioral and social science investigation into problems of severely and profoundly retarded.

Investigation is needed into the problems of the mildly and moderately retarded. Some mildly and moderately retarded persons are diagnosed as "undifferentiated" retarded. This means that a clear cut diagnosis cannot be made. At present, it is possible to attribute specific diagnoses to only 15% to 25% of the retarded population. For the most part, these are more severely and profoundly retarded. A great deal of research funds and energies concentrate on investigating the prevention and etiologies of the 15% to 25% of the retarded population who have specific diagnoses, usually of an organic nature. Research into the prevention, treatment and cause of retardation among the remaining 75% to 85% of the retarded is vital.

Mild and moderate retardation presents the most fertile

unploughed area for increased behavioral, social science and biomedical research.

Research in the biomedical, behavioral and social science areas must be stimulated if the etiology, definition, means of measurement and prevention of mild and moderate retardation is ever to be found. Development of objective and reproducible instruments to assist in the classification and measurement of the degree of retardation should be an early research goal.

RESEARCH IN THE STATE DEPARTMENTS

Research Units in the State Departments

Progressive industries routinely devote from 3% to 5% of their annual budgets to research development. The Joint Commission on Mental Illness and Health indicated that progressive states allocated 4% of their mental health budgets to research. Health research is supported by 4% to 5% of national expenditures for health. The formal budgetary allocation for research in Massachusetts state departments is well below this ideal level. For example, the Department of Mental Health allocates only 0.36% of its funds for the budgetary support of its research endeavors.

The Departments of Mental Health, Public Health, Public Welfare, Corrections, the Division of Youth Service and the Massachusetts Rehabilitation Commission, all have a legal mandate to conduct research. For example, the Department of Mental Health has the duty to make investigations and inquiries relative to all causes and conditions of mental illness, retardation and epilepsy, and to disseminate this information. Other departments have similar research responsibilities in the areas relevant to their interests. These state departments do conduct research, but to varying degrees. Some have research units in departments which serve merely as statistical gathering units. Others support large basic research endeavors. Some departments have research units that retain control over research conducted in the regional and local offices. Others do not have what can realistically be called a research unit.

Research units are necessary in each of the state departments to conduct research, as well as to supervise research activities under their department's auspices. Funds are necessary for proper staffing of such a unit, as well as for research within these units. State funds should be allocated to each department's research unit totalling 4% of the service budget. Research allocations should be made without the diminution of the service portion of the budget.

Within each research unit of a department serving the retarded, retardation research should be conducted. Funds allocated for retardation research should be roughly proportional to the funds allocated to the retarded in the service budget. For example, the Department of Education has a total service budget of approximately 55 million dollars and utilizes about 5 million dollars of this budget for services to the retarded. The research unit should receive roughly $200,000, 4% of the retardation service budget, to be spent on retardation research.

Staffing Research Units

Research units should be directed by professionals with experience in administration and research. Research units should include program analysts, who would be primarily engaged in evaluative and operational research relating to the department's service programs. Assistants, clerks, and technicians would be necessary, dependent upon the size and demands of each department.

Funds within each department's research budget should be earmarked for the utilization of research and statistical consultants. The use of outside experts would not burden the state with unneeded expense and personnel while permitting research units to obtain the best professional assistance available.

Direct service personnel may have a different perspective toward retardation services and activities than research investigators. However, direct service personnel can make original and useful contributions to research efforts. Service personnel in each department should be encouraged to make suggestions and participate in research activities. This would help to facilitate a better atmosphere for research within state departments. To help instill an atmosphere conducive to research and communication, as well as to help in the recruitment of personnel of high capacity, it should be clearly stated in recruitment procedures and job descriptions that research is not only an acceptable responsibility, but a desirable extension of activity for all professional personnel.

Coordination of Research in State Departments

To avoid duplication, as well as to facilitate coordination and cooperative programs, the research directors of the various state departments concerned with retardation should meet regularly. They should form a committee which should have the problems and issues of retardation research in the state departments as one of its main concerns. To conduct an adequate review of the retardation research situation, personnel from private organizations should be invited to these meetings, as the committee deems necessary.

Research in the State Facilities

State schools for the retarded are ideal field laboratories for retardation research. Two of the state schools, Walter E. Fernald State School and Wrentham State School, have research units. Activities of the personnel, as well as the results they have produced, reflect well on the quality of research in this type of institution. Fourteen of the 22 Massachusetts research projects reported since 1949 to the Children's Bureau Clearing House for Research in Child Life took place at state schools.

In 1964, four of the 14 projects in retardation funded by the Public Health Service were conducted at the Department of Mental Health's state schools for the retarded: two at Walter E. Fernald and two at Wrentham.

Research departments in Walter E. Fernald and Wrentham State Schools have proven to be valuable and productive. All other state facilities for the retarded, either now in existence or to be established in the future, should develop research units. To achieve the required level of research competency, research advisory boards, similar to those now existing in the Walter E. Fernald and Wrentham State Schools, should be established.

A study should be conducted at Paul A. Dever, Belchertown and Hathorne State Schools to plan for implementation of research units, since these institutions presently lack adequate units. An advisory board and cooperative arrangements with interested hospitals and universities should be considered in these studies.

University and Hospital Affiliations

Relations with interested hospitals and universities are necessary if research is to be conducted at the desired level of quality. Cooperative working arrangements could go far toward improving service activities, as well as research programs.

To reap as much benefit as possible from the university and hospital personnel using state schools for research, these

investigators should not only be responsible for their research studies, but also should be available for consultation to professionals in the state schools. In addition, these university and hospital researchers should augment the service personnel, if possible. This type of relation can be initiated by the further use of joint appointments between state facilities and universities and hospitals. Cooperative arrangements of this nature would provide these outside investigators with a deeper insight into the problems and operations of these institutions, as well as a more meaningful knowledge of the retarded population.

The introduction of research activities within a direct service agency can help to stimulate improvements and quali tatively upgrade services. To accomplish this, the proposed Office of Retardation should work with both the state schools and universities and hospitals. Universities and hospitals should be made aware of their increasing community responsibility to the mentally retarded. Effort should be made to establish joint clinical and research programs and appointments between state departments and facilities serving the retarded and hospitals and universities.

CENTRAL RESEARCH MECHANISM

Current inflexible and restrictive state administrative, personnel and fiscal procedures should be revised in order to encourage state departments to apply for federal grants. The present restrictive policies of approvals, personnel and civil service requirements sometimes hamper the development and expansion of research activities by state departments and frequently necessitate the utilization of private research corporations. There should be established within the state government a mechanism for receiving and dispersing public and private health, education and welfare research funds. This mechanism should encompass all relevant state agencies. Responsibilities should be to conduct research studies in all fields, one of which should be retardation. This mechanism should be responsive to the needs of individual investigators. The cost of this mechanism should be covered by the 15% overhead allocation included in federal research grants. Ideally, this mechanism should function independent from the state government, but its public responsiveness should be assured by the appointment, by the Governor, of a board of public servants to provide policy direction.

Until such time as this mechanism is established, private research corporations should be encouraged to continue to request, receive and disperse funds for financing research studies within state departments.

VITAL STATISTICS

Basic statistical information regarding the retarded is difficult to ascertain and not readily available. A coordinated system of vital statistics in this state would be a major step toward providing baselines for researchers to use in studies.

In 1960 the Public Health Service published a revised "Model Vital Statistics Act," to be used by the states as a guide in the revision of vital statistics laws. This model act enumerates the responsibilities of a Bureau of Vital Statistics administratively placed within state departments of public health. In Massachusetts the responsibilities for vital statistics is administratively splintered between the Secretary of State and the Department of Public Health. At the present, the office of the Secretary of State has the responsibility for the registration of birth, death, marriage and divorce information. The Department of Public Health, Division of Local Health Services, is responsible for processing this data. The model act, approved and recommended by the Public Health Service, the Association of State and Territorial Health Officers and the American Association of Vital Records and Public Health Statistics, calls for the centralization of the Bureau's responsibility and the installation of a system of vital statistics. A system of vital statistics includes the registration, collection, preservation, amendment and certification of vital statistics records and activities related thereto including tabulation, analysis and publication of statistical data derived from such records.

Massachusetts should adopt this model and the Department of Public Health should be assigned the responsibility of maintaining the system of vital statistics for the state.

This bureau should give special attention to the collection of material relevant to birth defects and retardation. This material should be recorded on the confidential section of the birth certificate available to researchers in all fields.

STIMULATING PRIVATE RESEARCH

Universities and hospitals are the primary recipients of federal research funds. Combined, they received more than 82% of the research funds awarded to Massachusetts in 1965. In addition, they were engaged in almost 85% of the federally sponsored projects. Investigators in only nine institutions, four universities and five hospitals, received more than half of all the Public Health Service grants issued to Massachusetts personnel.

Of 14 Public Health Service retardation grants received in Massachusetts in 1964, hospital and university personnel received eight.

State schools, universities and hospitals account for almost all the federally supported retardation research in Massachusetts. Research laboratories and private health foundations account for another, but smaller, portion of the federally supported retardation research. Only a few direct service agencies are engaged in any retardation research.

Hospitals and universities in Massachusetts have the professional personnel equipped to engage in research at a desirable level of competency. The proposed Office of Retardation should further encourage retardation research in these institutions. One method the Office should use would be the provision of "seed money" to personnel in these institutions. In addition, the Office should provide these institutions with information about sources of funds for retardation research. Staff members of the Office of Retardation should be available to act as research consultants, both on grant applications and project activities.

STIMULATION OF VOLUNTARY FUNDS

The National Association for Retarded Children and the Joseph P. Kennedy Memorial Foundation are examples of private voluntary organizations that allocate a portion of their budgets to retardation research. In a sense, the Kennedy Foundation awards "seed money" grants by providing funds for the construction of research facilities. The National Association for Retarded Children and some of its local affiliates provide research funds to persons who are involved in retardation research projects. Very little support is available for retardation research from other private voluntary sources. The proposed Office of Retardation should encourage those foundations which do not now support retardation research to review their granting procedures toward including funds for retardation research projects. All private and voluntary agencies supporting research should be encouraged by the Office of Retardation to initiate procedures for granting "seed money" for preliminary research.

Private foundations supplement and in some cases stimulate federal government programs of research grants. Private foundations can play an important role as providers of "seed money," small research grants and matching funds to federal grants. The Office of Retardation should encourage support of retardation research by voluntary research organizations by disseminating information about the granting policies of these organizations to research personnel.

STATEWIDE COMMUNICATION

Unless research findings can be communicated to other interested persons, investigations are only valuable to those individuals conducting the projects.

Symposia, such as those conducted by the New York Academy of Sciences and the Joseph P. Kennedy Memorial Foundation, are models for the communication of research methods and findings. The proposed Office of Retardation should establish a semi-annual interdisciplinary retardation symposium including participation from researchers and personnel engaged in service in public and private agencies. Proceedings should be published and distributed by the proposed Office of Retardation.

CENTRALIZED RESEARCH FACILITIES

At the present time a number of state agencies utilize data processing equipment of various kinds. In addition, many of the same agencies are considering the purchase or rental of new equipment. The Office of Administration and Finance has begun to study methods for more efficient utilization by all concerned departments for the procurement of expensive data processing equipment. This action should be encouraged and expanded to include more comprehensive exploration of methods for coordinating research efforts and pooling statistical information when appropriate. This would be especially useful with respect to health, education, welfare and corrections agencies concerned with many overlapping interests in the provision of human services including those for the retarded.

SAFEGUARDS IN RESEARCH

Cognizance should be taken of federal regulations that must be met when research involving humans is financed by a federal grant. Appropriate standards and safeguards should be developed by the Office of Retardation which are at least equal to those established by the U. S. Public Health Service. Safeguards and standards should be met when either private or state funds are used in research programs involving retarded persons. A study by the Office of Retardation should determine the most effective and impartial administrative methods for approving research projects.

Safeguards for research subjects should include:

- Protection of the rights and the privacy of the individuals involved.
- Prevention of any possible abuse in use of persons who may not be able to comprehend the program in which they are participants.
- Consideration of potential risks to subjects and other factors in relation to the potential medical or social benefits that would result from the research.

PUBLIC AND PROFESSIONAL AWARENESS

RECOMMENDATIONS

COMMUNICATIONS AND EDUCATION UNIT

259. A Communications and Education Unit should be established to assume a leadership role in all information programs and responsibility for disseminating appropriate information to specific professional and lay groups.

The Office of Retardation, in collaboration with the Health and Welfare Commission, should study the most appropriate location for the Communications and Education Unit and recommend a permanent location to the Governor.

ADVISORY BOARD

260. An interdepartmental technical advisory board to the Communications and Education Unit should be appointed to assist in formulating communications policy.

REGIONAL HEALTH EDUCATORS

261. The position of regional health educator should be established on the staff of the Communications and Education Unit to help coordinate and disseminate information regionally and to stimulate educational programs among professional groups, local agencies, civic, service and religious organizations.

REGIONAL COMMITTEE

262. Regional committees should be established throughout the state, composed of appropriate professionals, administrators and lay persons, to facilitate the dissemination of health information locally and feed back matters requiring state level consideration.

AREA HEALTH EDUCATION LIAISON

263. A staff person in each mental health-retardation area should be designated by the area director to assist in the dissemination of retardation information in the area and to cooperate in any other appropriate way with the regional health educator.

DISSEMINATION TO DEPARTMENTS

264. One staff member in every state department should be designated to receive materials from the Communications and Education Unit and to disseminate these among appropriate staff in their department.

COMMON TERMINOLOGY

265. Common terminology should be agreed upon among professionals and utilized consistently in all communications directed to the public and to professionals.

COMPILING INFORMATION

266. Materials in the field of retardation should be compiled and evaluated by the Communications and Education Unit with respect to their impact in changing attitudes and stimulating desired action among professional and lay groups.

LIBRARY RESOURCE CENTERS

267. Resource centers should be established in existing libraries where the latest information on retardation would be available.

MASTER DIRECTORY

268. Existing master directories of community resources for retarded persons should be updated, kept up to date and prepared by the Communications and Education Unit with sections which are relevant to specific professionals and lay groups.

DISSEMINATION OF RESEARCH RESULTS

269. Reports of research, demonstrations and professional experiences which point out successful methods in education, training and management of retarded persons should be disseminated by the Communications and Education Unit to all pertinent professionals, agencies and organizations.

COMMUNICATIONS RESEARCH

270. Opinion surveys should be conducted or stimulated by the Office of Retardation to assess the attitudes of various professionals and pertinent segments of the public towards the problem of retardation, to provide guidelines for the development of appropriate messages and the most effective media for dissemination.

INCLUSION IN CURRICULUM

271. Appropriate curriculum material about the field of retardation should be prepared by the Communications and Education Unit and its use stimulated in professional schools.

PROFESSIONAL CONFERENCES AND MEETINGS

272. Special invitational conferences and meetings on retardation should be arranged for leaders of various professional organizations to acquaint them with basic issues in the field.

WHY COMMUNICATE?

It is often more difficult to make a case for expenditures in public relations, health education and communications than for more direct and specific services. However, many of these specific services derive their underlying support from proper interpretation and the dissemination of appropriate information to selected individuals and groups.

In the field of retardation adequate communication on all levels is particularly important. Many new responsibilities are being undertaken by professionals and by public and

voluntary agencies in direct services and research. The development of mental health-retardation centers and the decentralization of services within local communities will bring about the involvement of persons from all walks of life on boards, committees and as neighbors of new facilities.

The extent and nature of their help will be a result of their level of knowledge and of their attitudes about retarded persons.

Emphasis on an interdepartmental and multiprofessional approach towards the solution of problems in the field, requires the development of a mechanism for the dissemination of information and for communication which will keep persons on a state and local level appraised of developments in this field. No mechanism presently exists which provides for an adequate delivery of information which could keep pace with a changing and expanding situation.

A COMMUNICATIONS AND EDUCATION UNIT

Purpose

The major purpose of the Communications and Education Unit should be education and enhancement of the flow of information to specific professional groups, identifiable groups within the public, state agencies and public and private organizations. With the increase in the flow of information, it is hoped to ultimately stimulate action and change attitudes. The following are examples:

- Communications to convince dentists to accept retarded persons as patients.
- To disseminate information about new teaching methods and techniques to special class teachers which may be utilized in their work.
- To disseminate information which will influence suitable industries to hire retarded persons.
- To provide information to school committees which will influence their decision to allocate funds for preprimary classes for moderately and severely retarded children in their community.
- To provide speakers for meetings to help gain acceptance for a group home for retarded young adults by neighborhood residents.

Administrative Location

The administrative location of the Communications and Education Unit must be closely related to its over-all functions. As presently proposed, the unit is sufficiently large, so that it may assume responsibility for other health functions in addition to retardation.

On the basis of these expanded responsibilities, the Communications and Education Unit might be located within the Health and Welfare Commission, serving the needs of the participating departments, or it might be integrated in an expanded Division of Health Education of the Department of Public Health, so that production skills may be centralized for all governmental agencies.

The Office of Retardation, in collaboration with the Health and Welfare Commission, should study the most appropriate location of the Communications and Education Unit and recommend a permanent location to the Governor.

Selecting Message Content and Target Groups

Selection of the content of the message and the target groups must be consistent with statewide plans for retardation programs. Priorities for message content should be determined by the proposed Office of Retardation in respect to retardation and by other departments if the Communications and Education Unit assumes responsibility for other health functions in addition to retardation.

Compilation of Pertinent Data

The staff of the Communications and Education Unit will require a great variety of information in preparing appropriate materials. They should have at their disposal complete information regarding research data, studies in progress as well as statistical information. However, they should not be responsible for collecting and categorizing this information, a responsibility which might be better fulfilled by the research and statistical divisions of the respective departments.

Preparation of Materials

Communications and Education Unit staff should decide on the most appropriate materials for disseminating the required information and the best means of reaching the selected target group. Much of the required material may have to be prepared by the staff of the Communications and Education Unit, or by others under their guidance. Existing and new materials prepared by various professional groups should also be utilized, if and when appropriate.

Compilation and categorization of existing and new audio visual material should be the responsibility of the Communications and Education Unit. Information regarding such materials should be made widely available.

Selecting the Media

Newspapers, television, radio, magazines, professional journals and all other media should receive consideration in the dissemination of information. While these mass media may serve for the dissemination of information which has general applicability, serious difficulties may arise in communicating with specific groups unless local forms of communication are understood and local resources and leadership are known. In many respects the same consideration applies to the dissemination of information within respective state departments, which require an understanding of the administrative structure and the informal channels of communication.

Health educators should work in various areas of the state to help interpret materials to specific local groups, to establish channels of communication with local agencies and to help the staff of the Communications and Education Unit to formulate materials which will have the greatest impact in the area.

ILLUSTRATIONS OF THE ACTIVITIES OF THE COMMUNICATIONS AND EDUCATION UNIT

- To prepare or to stimulate the preparation by professionals of materials directed at specific professional groups providing content in respect to research, programs, methods, inservice training and recruitment.
- To take an active role in the dissemination of information, and to initiate contact with public agencies, voluntary groups, legislators, school boards and other concerned individuals and organizations through the regional councils.
- To assume the responsibility for the creation of program packages in retardation and other fields to be used at professional meetings.
- To develop and assume the responsibility for the creation of program packages to enhance recruitment to be used with high school, undergraduate and graduate students.
- To administer a speaker's bureau in retardation and other fields for professional and lay meetings and for other situations where expert interpretation of issues are required.

- To develop films, slides and other audiovisual material to highlight vital information about retardation and other fields.
- To compile and categorize existing audiovisual material on retardation and other fields and to keep the listing current.
- To utilize the closed circuit educational television channels being constructed at the new Health, Education and Welfare building, Boston. To develop audiovisual aids which are suitable to this medium, as well as to public television and contain information pertinent to groups which can be reached in this way.
- To develop, or provide consultation in the development of teaching records for various professional schools, which highlight that profession's responsibility and service potential in the field of retardation and in other fields.

STAFF OF THE COMMUNICATIONS AND EDUCATION UNIT

Because of the broad responsibilities envisioned for the Unit, staff members should be knowledgeable about retardation, about the utilization of audiovisual materials, about research and have the ability to interpret the use of this material to key persons in various professions as well as to the general public. For a suggested table of organization see Chart 1.

Annual Cost

The annual cost for staffing the Communications and Education Unit is estimated at approximately $215,000. This does not include the initial purchase of equipment which will be approximately $30,000. It is recommended that the expenses for materials and supplies be charged to the departments and divisions receiving services.

Technical Advisory Board

A technical advisory board to the Comunications and Education Unit should be established. It should be composed of top level personnel from the following departments and organizations: Department of Mental Health, Public Health, Education, Correction, Public Welfare, Labor and Industries, Rehabilitation Commission, Division of Employment Security, Division of Youth Service, Office of the Attorney General, Office of the Commissioner of Probation, Massachusetts Association for Retarded Children and other appropriate state level health and welfare agencies.

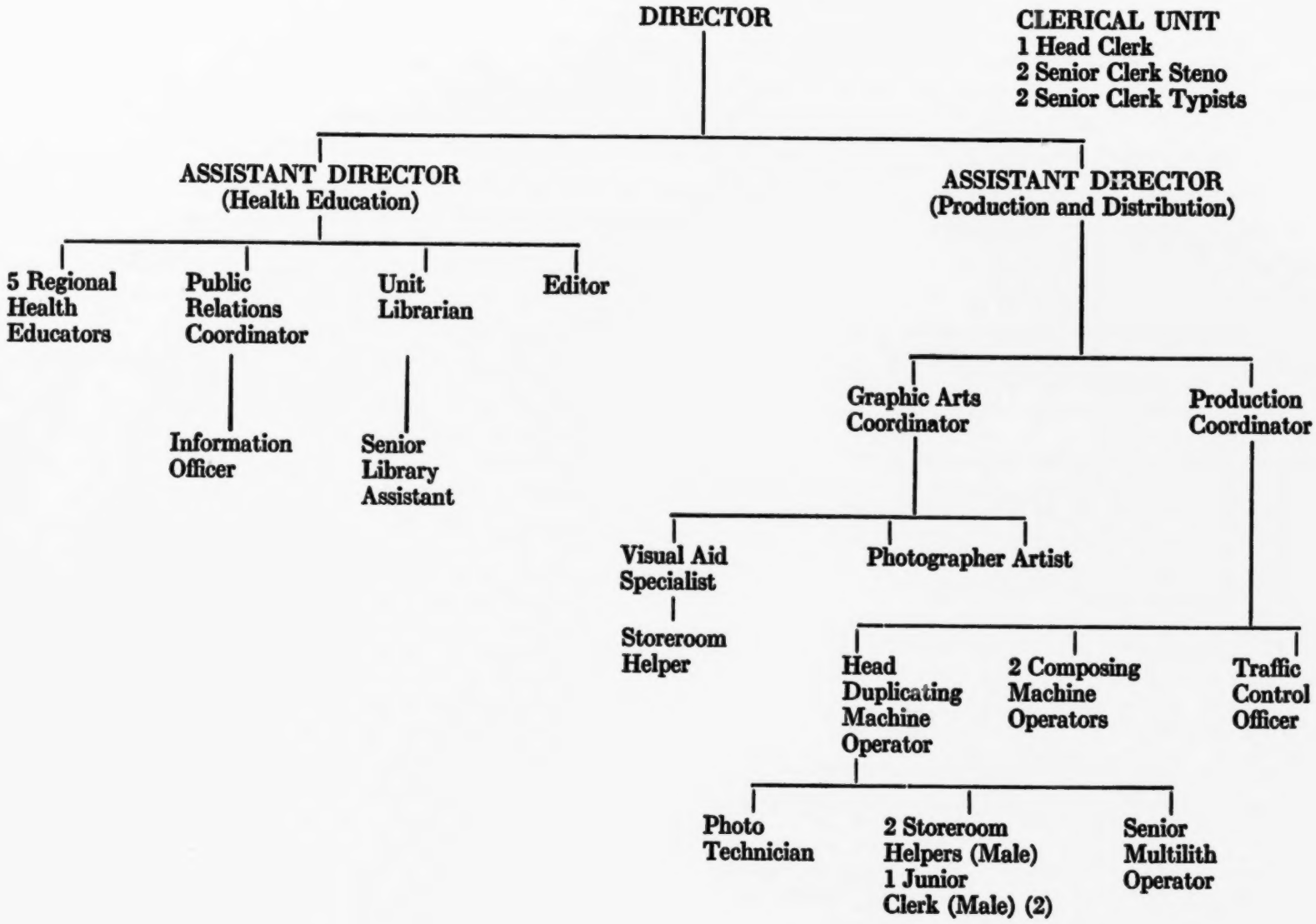
The technical advisory board should help to set policy for the Communications and Education Unit and coordinate the communications requirements among the organizations they represent.

Regional Health Educator

Positions for at least five regional health educators should be established on the staff of the Communications and Edu-

CHART 1

Communications and Education Unit



cation Unit. They should be responsible to the Assistant Director (Health Education). Regional health educators could work out of mental health-retardation centers throughout the state.

These staff members should assume responsibility for the stimulation of educational programs within their regions, the coordination and dissemination of information to local agencies, the interpretation of new programs within their area to appropriate local groups, and support the work of the Communications and Education Unit in their region.

The regional health educator should help to establish and to staff a regional committee. He should become fully aware of local and regional communications problems and feed back regional and local requirements to the state level staff for their attention.

Additional health education staff to function under the supervision of the regional health educator should be employed as the need arises.

Regional Committee

A regional committee should be formed by the regional health educator. This committee should be composed of representatives from local agencies and voluntary groups, who can be instrumental in the dissemination of information and make the regional health educator sensitive to local requirements.

Area Health Education Liaison

A staff person in each mental health-retardation area should be designated by the area director to assist in the dissemination of information in the area covered by the center, and to assume the role of liaison between the mental health-retardation center and the regional health educator, when indicated.

Dissemination of Information to Departments

The responsibility for retardation information should be assigned permanently to staff persons in each state department. This is necessary because of differences in administrative structures, and the nature of retardation services being offered by various agencies. Specific staff persons should be designated to receive and direct materials where they will be most useful in their departments. In turn, they would inform the staff of the Communications and Education Unit of the requirements of their department for materials and information.

The following departments should designate a staff person as communications liaison: Mental Health, Public Health, Education, Correction, Public Welfare, Labor and Industries, Rehabilitation Commission, Division of Employment Security, Division of Youth Service, Office of the Attorney General, Office of the Commissioner of Probation.

COMMON TERMINOLOGY

It is imperative that common, basic terminology be agreed upon among professionals. Terms such as mild, moderate, severe and profound retardation, cultural deprivation and mental deficiency should take on a common significance to facilitate communication. The Communications and Education Unit can influence common usage by setting early policy regarding terms to be used in the preparation of materials.

Interprofessional meetings among leaders from various groups might help reach agreements on terminology which should be widely publicized through professional journals in the literature.

The terminology and classification arrived at by the American Association on Mental Deficiency is a reflection of the changes taking place and may constitute a basis for agreement.

Common usage among the public does not appear to be likely when there is a lack of professional consensus about terminology. Attempts to arrive at a common terminology should first be made among professionals through professional organizations, through professional literature, and through professional schools.

SUGGESTED MESSAGES

There is little agreement at present as to the priorities which should be accorded to certain types of information. Many may have equal urgency. An over-all plan for raising the level of public and professional awareness should be developed which contains priorities based on expert opinion as well as the results of opinion surveys and attitude studies.

Following are examples of the type of content and the variety of target groups which must be considered in the compilation of materials:

Across the board messages:

- Retardation varies in degree. Only a minority of retarded persons are profoundly retarded or helpless.
- A retarded person may have limitation in only some areas and function well in others.
- Retarded persons are no more dangerous or criminally inclined than persons who are not retarded. They should live in the community whenever possible.
- Retarded persons need certain special educational and vocational services which can help many to learn to function more independently and become contributing members of society.
- Many services provided locally or regionally will receive wider use and cost less money than their centrally located, residential alternatives.
- Tax expenditures for state and local services and for staff should receive public support.

Specific Messages:

Employment

- Demonstrating to potential employers the feasibility of hiring retarded persons.

Education

- Developing a favorable and knowledgeable attitude on the part of school committees regarding special class services and the importance of vocational preparation so that adequate funds will be approved.

Prenatal Care

- Enhancing the use of a variety of preventive measures to guard against retardation such as the use of medical services during pregnancy and caution in the use of drugs

Mothers of Very Young Children

- Methods for providing adequate stimulation to infants and toddlers to help in their full development.

Families of Retarded Persons

- Disseminating information regarding available community services which families of retarded children might use.
- Educating families to utilize the established services in the community.

LIBRARY RESOURCE CENTERS

One of the major problems in the field of retardation is the inadequate use being made of the information which is known, and the negative assumptions which sometimes fill voids in knowledge. Even though there is a continued need for new research and demonstrations, existing information is being put to only limited use. Much could be gained through the advantageous utilization of currently available knowledge and the improved dissemination of new information to appropriate individuals.

Existing, centrally located libraries should be utilized as resource centers, where current information on retardation would be available. These libraries should have films, books and other materials about retardation available for distribution. Appropriate materials prepared by the Communications and Education Unit should be distributed to local libraries. However, local funds should be utilized to purchase additional materials. Staff members of local libraries should be capable of providing help to individuals and agencies in securing needed information, or in directing them to appropriate materials.

USE OF ELECTRONIC EQUIPMENT

One central library in Massachusetts should contain complete resources in the field of retardation. Arrangements are underway between the Massachusetts Department of Mental Health and the Harvard Countway Library to store materials in medicine and medical history in respect to retardation. The counterpart of these facilities for the behavioral sciences has been established at the Institute for Scientific Information, Philadelphia. Arrangements have not been made for using their facilities to store information on retardation. As a combined resource these libraries, with their electronic equipment could potentially provide information for the entire field of retardation.

The use of newly available resources should be stimulated. A selective bibliography in retardation should be developed and annotated to simplify the location of specific information with cross categories uniquely applicable to each profession. Bibliographies must be kept current.

Current indices of available material should be distributed regularly to each state department and should also be available to voluntary agencies throughout Massachusetts.

MASTER DIRECTORY

A resource handbook listing detailed information on the full range of services currently available to retarded persons within Massachusetts, including intake policies, costs and locations, should be updated and kept up-to-date by the Communications and Education Unit with the direction of the Office of Retardation. Sections should be prepared which are relevant to specific professional and lay groups. Services offered to retarded persons by state departments should be explained in detail.

DISSEMINATION OF RESEARCH RESULTS

Results of ongoing basic and applied research in retardation should be disseminated to individual professionals and to the staffs of agencies and departments, who would find such results significant in their work. This responsibility should be assumed by the staff of the Communications and Education Unit with the direction of the Office of Retardation. One means of making research results known is through articles and announcements in professional journals.

As much hard data as is available about mildly and moderately retarded persons should be disseminated to professionals. Data should include information on etiology, prevalence, methods of diagnosis and techniques in education, recreation, training and available services and facilities. Much of this information is not yet fully known. Facts should be clearly separated from assumptions.

Information should be prepared separately for each professional group keeping within the frame of reference of that profession. Dissemination should be through sources which are known and respected within that profession in terminology which is readily understood.

Where indicated the Communications and Education Unit should stimulate professionals to prepare materials dealing with important findings in their field in research, programs, methods, inservice training and recruitment.

COMMUNICATIONS RESEARCH

There is little firm data to indicate the present state of public and professional awareness and of prevailing attitudes regarding retardation. Although there is nonstatistical indirect evidence to indicate that the knowledge level is low and the prevailing attitudes still negative, surveys among employers, educators, high school students, and a host of professions may make it possible to focus the content and make the communication more effective.

One illustration of the need for communications research concerns the question of whether certain groups within the public should be enlightened about the requirements and the potential of mildly and moderately retarded persons, or whether information in this area should be confined only to professional groups.

It may be possible to "sell" the mildly retarded if we are able to show the "public" that they are capable of fulfilling specific functions in our society. However, the protective mantle of sympathy which the public may extend to more severely retarded persons is not likely to be offered to the mildly retarded. This is particularly true because the majority of this group may not perceive of themselves as retarded and may reject the label and the stigma which our society attaches to it.

Although generic professional services are needed by all persons who are retarded, there are important differences in the requirements of mildly and moderately retarded individuals from those who are severely and profoundly retarded. Service needs of persons who are mildly and moderately retarded must be more clearly identified and communicated to appropriate professionals. A great deal is still not known however about the type of information to which professionals would be most receptive.

The negative image which is evoked by the unqualified labeling of persons as retarded will be difficult to overcome without additional communications research.

Some of the following professional and lay attitudes about retarded persons appear to be prevalent, but verification is lacking:

- There is a tendency to associate "retardation" with the condition of severe and profound retardation, often including physical stigmata. The picture about mild and moderately retarded persons and the nature of their impairment is generally vague.
- Retardation is often perceived as a total, rather than a variable disability, in which only certain areas of functioning are impaired.

- It is not widely known that recent evidence indicates that retarded persons, on all levels, may respond to education and training to a greater extent than was previously thought possible.
- Many professionals feel that the great investment of time and resources to work with retarded persons might be utilized to greater advantage elsewhere.

CURRICULUM DEVELOPMENT

An effort should be made to retain retardation on some level within the curriculum of all professional schools whose work is directly or peripherally necessary to retarded persons.

Although special courses in retardation may not always be feasible, discussions with school administrators and curriculum planners might consider seminars, classroom presentations, work placements and visits to facilities serving retarded persons. These should be geared to provide suitable substantive material as well as to stimulate interest in the field of retardation as a career.

Lifelong attitudes are formed by students while they attend professional schools. The absence of retardation as part of the curriculum in professional schools creates an obstacle in changing attitudes of individual professionals toward retarded persons. Consequently their concept about retarded persons tends to be vague and may be erroneous. In addition, the absence of retardation in the professional curriculum lowers the status of the field in the eyes of professionals. It also limits the skill and experience of students with retarded persons and precludes opportunities which might create interest and provide professional satisfactions.

PROFESSIONAL CONFERENCES AND MEETINGS

Channels must be provided for an exchange of information among professionals to encourage a multidisciplinary approach to the multifaceted services required by retarded persons.

Professional meetings are an excellent opportunity for disseminating certain information about retardation. However, the subject of retardation generally has secondary status on the program at professional meetings. Broader coverage is most desirable in stimulating discussions and in airing issues. Program committees for professional meetings would welcome presentations in the field of retardation provided they were complete high quality program packages. These could be developed along the lines of those produced by the Communicable Disease Center of the Public Health Service, which provides professional groups with a program portfolio from which they may select different, complete programs deemed to be of the greatest interest to their members. The use of speakers, exhibits, printed materials and other audiovisual aids produces a clear, concise and interesting story geared to a specific profession. A number of speakers from retardation and allied fields should be recruited as a rotating panel, who would be available to participate on the basis of their particular competence as part of a "program package". The creation and stimulation of the use of "program packages" and the administration of the speakers bureau are among the responsibilities of the Communications and Education Unit.

Special invitational meetings dealing with retardation should be held for leaders in various professions. Meetings should take place in a congenial setting, lasting for a day or weekend. Basic issues in retardation should be discussed as well as the means of increasing services to retarded persons.

FINANCING COMPREHENSIVE RETARDATION PROGRAMS

MULTISOURCE FUNDING

Financing retardation programs should continue to be the prime responsibility of the Commonwealth. However, this does not mean that funds must be derived exclusively from Massachusetts tax dollars. All sources of revenue must be utilized. The concept of multisource funding of retardation programs is well developed in Massachusetts. In 1848, the first legislative appropriation on behalf of the retarded was made with the understanding that private interests should share the cost of service. Today, individuals, families, voluntary associations, foundations, as well as state, local, and federal government share the cost of retardation programs. In recent years the Congress has acted to increase federal funds for state retardation programs through laws such as the Social Security Amendments of 1965 (P.L. 89–97); the Elementary and Secondary Education Act of 1965 (P.L. 89–10); the Vocational Rehabilitation Act Amendments of 1965 (P.L. 89–333); the Mental Retardation Facilities and Community Mental Health Centers Construction Act Amendments of 1965 (P.L. 89–105); and the Maternal and Child Health and Mental Retardation Planning Amendments of 1963 (P.L. 88–156).

Maximum utilization of federal funds combined with reasonable and effective fee for service arrangements, where applicable, will help to meet the cost of retardation programs. Nevertheless, it is ultimately the responsibility of the Commonwealth to insure that financial support will be adequate to meet the needs of the retarded and their families.

CURRENT AND FUTURE COSTS

Massachusetts currently spends $50 million per year on behalf of the retarded. An additional annual expenditure of nearly $14 million will be required in fiscal 1968 to catch up with accumulated program deficits. By 1976, an additional annual expenditure of $45 million will be required to implement the entire proposed plan. The Commonwealth's total financial commitment for operating retardation programs in 1976 will be approximately $94 million per year, an increase of 92% over current expenditures.[1]

Financial estimates are based on current costs of operation. No adjustment has been made for inflation and changes in fringe benefits.

Unless otherwise noted, construction costs are not included. Actual construction costs depend on a number of variables, such as geographical location, conditions in the construction industry and type of construction. It is assumed that the Department of Mental Health estimates for a $60 million capital outlay for retardation facilities over the next 10 years are a reasonable projection of construction costs.

FINANCING COORDINATION AND COMMUNICATION

While Massachusetts spends $50 million annually in behalf of the retarded, not one dollar is directly appropriated for interdepartmental coordination or for public and professional information and education programs. Mechanisms to bring about effective communication and coordination in retardation programs can be established at a relatively small cost — less than 1% of present retardation expenditures.

Financing coordination and communication requires budgetary support for the proposed Office of Retardation, the proposed Communication and Education Unit, and administrative positions recommended for the Departments of Education, Public Health, Public Welfare and the Massachusetts Rehabilitation Commission.

The Office of Retardation will require an initial appropriation of slightly more than $100,000 to operate effectively. Professional staff salaries constitute the major cost and include funds for one director, a deputy director, five associates, clerical staff and office space and supplies.

Administration of retardation programs must also be strengthened at the departmental level. Positions of Assistant Commissioner for Retardation should be established in the Department of Public Welfare, the Department of Education and the Rehabilitation Commission, and the position of Chief Retardation Coordinator in the Department of Public Health. A sum of $45,500 should be budgeted to attract qualified individuals for these four positions.

To assure a flow of accurate and reliable information as well as appropriate educational efforts, $245,000 is needed to finance a Communications and Education Unit. Activities of this Unit should insure that the Commonwealth's investment in direct service to the retarded will actually be brought to the attention of the public. The proposed budget would include funds for a director, an assistant director, production and distribution personnel and additional supporting staff.

Coordination and communication costs outlined above are a small price to pay to insure that the many millions of tax dollars spent on retardation programs in the Commonwealth are used effectively and efficiently.

FINANCING COMMUNITY SERVICES

Cost of comprehensive community retardation services for a given area will depend on area population, existing services and need. Profiles of each area have been prepared, showing socioeconomic need, specialized need, and existing and planned facilities, but no cost analysis of existing and needed services is available. Therefore, it is not possible, at this time, to predict the exact outlay for each area. However, by making certain assumptions, the aggregate cost of providing comprehensive retardation services throughout the state can be estimated. It must be emphasized that the analysis that follows is of value only as a starting point for a more sophisticated cost analysis of the needs of each area.

Costs of operating comprehensive community retardation programs in each of 37 areas will depend on the need for specialized services within the area. Based on the experiences of the Worcester Area Comprehensive Care Center for the Mentally Retarded, plus the estimated cost of providing total day services and emergency residential care (25 beds), the annual operating cost of providing comprehensive retardation services in a population area of more than 200,000 people would be approximately $600,000. Assuming 37 retardation areas in 1975, the average area population would be approximately 165,000. The cost of making available comprehensive retardation services to this population is estimated at about 80% of the cost of a 200,000 population area, or approximately $500,000. Assuming that comprehensive services will be rounded out by the end of 1967 in those areas which have

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[1]Excludes projected costs for travel, fringe benefits, space, and supplies. Addition of these items would bring the total 1976 annual operating cost to more than $100 million, doubling the present level of expenditures.

existing specialized retardation facilities[2], an additional $1.5 to $2 million will have to be appropriated each year to finance community retardation services to attain statewide coverage by 1975. A suggested long range budget follows:

Year	*Cumulative Number of Programs*	*Cumulative Population Served*	*Cumulative Budget Increase*
1967	9	1,485,000	$ 4.5 million
1968	12	1,980,000	6.0 "
1969	15	2,475,000	7.5 "
1970	18	2,970,000	9.0 "
1971	21	3,465,000	10.5 "
1972	25	4,125,000	12.5 "
1973	29	4,785,000	14.5 "
1974	33	5,445,000	16.5 "
1975	37	6,105,000	18.5 "

The $18.5 million represents total operating costs and does not include capital outlay. Construction costs will be covered under proposed plans for construction and in part by federal funds under the Mental Retardation Facilities and Community Mental Health Centers Act of 1963.

RESIDENTIAL PROGRAMS

Financing residential programs involves the costs of:

- Meeting the current need for residential care.
- Upgrading existing residential programs.
- Reorganizing the state residential schools into regional centers.
- Introducing alternative forms of residential care.
- Restricting financial responsibility of parents and relatives to payments for noneducational expenses and for care of those residents under the age of 21.

In fiscal 1965, more than $17.5 million was expended to care for 8,324 residents in four state schools for the retarded, in addition to almost $9 million to care for retarded persons in Monson State Hospital and state hospitals for the mentally ill.

Average annual cost per resident at state residential schools ranged from $2,002 at Belchertown to $2,626 at Walter E. Fernald. This expenditure does not meet the expressed need for residential care. Taking into account the 903 persons on state school waiting lists (June 30, 1965) and the 2,238 state school residents in excess of rated capacity, the cost of providing needed residential care would be an additional $7 to $8 million for a total annual cost of nearly $34 million.

This estimate represents operation cost alone and does not take into account the cost of construction. A new regional center in Danvers, the conversion of the Veterans Administration Hospital in Rutland and plans for regional centers in Boston, Springfield and Worcester will provide more than 2,000 beds and go a long way toward meeting the current need for residential care. Based on construction costs for the Hathorne facility, each new 500 bed residential unit will require a capital outlay of about $9 million. Future demands for residential care will depend greatly on the availability of community services and alternative forms of residential care.

[2]Areas served by Worcester Comprehensive Care Center, Lowell Mental Health Center, Fall River Mental Health Center, South Shore Mental Health Center, Hathorne State School, Belchertown State School, Walter E. Fernald State School and Paul A. Dever State School.

Regardless of future expansion and development of new programs, personnel additions to the four large residential facilities should be provided immediately. Recommendations for increased personnel allotments made in the 1965 report of the Special Commission on Retarded Children are certainly endorsed. Authorization of these positions will require an addition of $1,856,209 to personnel budgets of the state residential schools — an increase of $933,058 for Wrentham State School, $354,105 for Paul A. Dever, $313,610 for Walter E. Fernald State School and $255,436 for Belchertown State School.

State school reorganization and the transition to regional centers will require new administrative staff. Each of the four state schools should have an Assistant Superintendent for Social Development, Education and Training; an Assistant Superintendent of Medical Services and an Assistant Superintendent of Management. Total salary requirements for these 12 positions will be about $178,584 per year. In addition, Directors must be appointed to the following functional units at each state school: Hospital, Infirmary, Children's Units, Adolescent Unit, Adult Unit, Research Unit, and Community Services Unit. Cost of these positions at each state school is estimated at $87,670; a total cost of $350,680.

Many retarded persons in state residential schools could function in and benefit from halfway houses, adult colonies, boarding homes and foster care arrangements. As these alternatives to residential school care develop, the demands on the institutions should be alleviated.

Currently, daily care at Walter E. Fernald State School costs $7.21. Cost of care in alternative residential settings would range from $6.00 to $8.50 per day depending on the services available in each setting. Halfway houses which are self sustaining may be developed, giving the resident an opportunity to pay his own way. Foster care should be expanded. The Division of Child Guardianship's regular board rate for foster homes amounts to $2.00 per individual per day. In addition, cost of medical care, clothes, school tuition and professional services are provided by the Division. Taking into account the rate for extra care paid to some foster parents, the total cost of care of a retarded child under foster care ranges from $3.00 to $5.00 a day. If the current board rate were increased to attract foster parents for the retarded, the cost of care would still be less than institutionalization. Developing other forms of care should be considered as an alternative investment which could result in long term savings by encouraging partial independent living and by cutting down on large capital outlay.

Under Chapter 123, Section 96, of the General Laws, fees are established and charges made to parents or responsible relatives for the care and support of residents in the facilities of the Department of Mental Health. In fiscal 1966, fees collected for the care and support of individuals in the four state schools amounted to about $1.5 million or approximately 9% of the total cost of care. The maximum daily fee, recently raised from $4.50 is presently $7.70. For those unable to pay the full amount, the Division of Settlement and Support waives or reduces support payments.

Any charge to parents for care in a state school should cease when the resident reaches the age of 21. Approximately 45% of the state school residents are over 21 years of age. Actual fees collected for the care of adult retardates are not available. Assuming that fees are collected for the care of adult residents in the same proportion as their numbers in the institutions, cost to those parents or relatives of residents over 21 years of age is about 45% of present collections or $675,000. The state should absorb this amount.

FINANCING EDUCATIONAL PROGRAMS

Financing recommended educational programs for the retarded will require a substantial increase in the expenditures of the Department of Education and local school departments. In addition, an increase in the expenditures of the Department of Mental Health for education in state residential schools will be needed.

Costs for public special class education are shared by local communities and the state. Under the law, the Department of Education reimburses local communities for one-half the cost of instruction, training and support of children in special classes for the retarded. One-half of the cost is provided for teachers' salaries, supervisors' salaries, psychologists' services, books, supplies and transportation. In addition local communities are reimbursed fully for salary differentials up to $500 paid to teachers of special classes for the retarded.

In fiscal 1965, state reimbursement to local communities for special classes for the retarded was approximately $4.5 million, and combined state and local expenditures amounted to approximately $9 million. These expenditures should more than double within the next 10 years, bringing the total annual operating expenditures for public school special classes for the retarded to about $20 million.

Teachers' salaries represent the major cost item in public schools' educational programs for the retarded. An expenditure of $5 million is urgently needed to hire more special class teachers and to provide more classroom space to comply with the recommended class size of 10 trainable pupils per class and 12 educable pupils per class. At least 120 new special class teachers are required immediately to provide the proper teacher-pupil ratio. An additional $1 million is required for recommended supervisory personnel.

After the current need is met, increasing enrollment and expanding programs in the kindergarten and vocational areas will all combine to place greater demands on local school systems and the Department of Education. If current trends in enrollment continue, a minimum of 800 additional teachers will be needed to staff special classes by 1975.

Early identification and comprehensive evaluation of retarded children within the school system will require an annual expenditure in excess of $2.3 million. Each year, up to 20,000 school children will need individualized assessment by multidisciplinary teams composed of a physician, clinical psychologist and social worker. To meet these needs an equivalent of 52 full time teams must be employed throughout Massachusetts. Some larger schools will require more than one team. Smaller school systems should purchase part time services or develop cooperative regional arrangements to maintain a full time team.

In some cases extended diagnosis will be appropriate. Depending on the nature and quantity of consultation involved, extended diagnosis may raise the cost of an individual evaluation $150 over the basic team cost of $115 per individual. The additional cost represents fees for neurological, psychiatric, speech, hearing or other consultants, who may be drawn from mental health programs.

Each individual in Massachusetts, regardless of condition or location, should have full access to educational services designed to assist him in achieving his maximum potential. This includes the 3,100 persons of school age residing in state residential schools and the 2,500 adult residents who could benefit from adult education.

Present appropriations for educational programs in the state residential schools are grossly inadequate. Total educational expenditures for the four institutions of slightly more than $1 million represents $325 per school age person or less than one-half the average per pupil expenditure for public school special classes. The reason for such a low expenditure per school age person is that many school age persons in state residential schools now receive no educational services at all.

Implementation of the recommendations for adequate educational programs in the state residential schools will require an additional $2 million, bringing the total education budget to more than $3 million. This includes $1 million for special subject teachers, therapists and additional educational and vocational training staff.

FINANCING VOCATIONAL TRAINING AND EMPLOYMENT

In recent years the demand for rehabilitation services for the retarded has grown considerably. Judging from increasing special class enrollment and other indicators, this demand will continue to grow in the next decade. To meet the need for vocational training and employment opportunities for the retarded, Massachusetts should take full advantage of all federal funds available under the 1965 Amendments to the Vocational Rehabilitation Act. Under the 1965 Amendments each dollar appropriated by the state legislature for vocational rehabilitation will be matched by three dollars in federal aid. Utilization of these funds will make possible the expansion of staff and vocational training services for retarded and disabled persons in the Commonwealth.

Although state appropriations for rehabilitation have tripled since fiscal 1960, the legislature has not authorized the Massachusetts Rehabilitation Commission to spend state funds sufficient to fully utilize available federal monies.

The Commonwealth forfeited $1,773,000 in federal matching funds from 1963 through 1965 and lost 42% of the federal funds available for vocational rehabilitation in fiscal 1966. Assuming the funds forfeited would have been distributed for services among the various disability groups in the same proportions as the actual allotments, an additional $360,000 in federal vocational rehabilitation funds would have been available for the retarded for the above four year period.

For fiscal 1968, the Commonwealth must appropriate approximately $2.5 million to earn $7.2 million in federal vocational rehabilitation funds. Based on previous experience, 10–15% of the total appropriation will be used to serve the retarded. Thus, an optimal state appropriation would make available at least $1 million for rehabilitation services for the retarded, well over twice the sum available now.

FINANCING LEGAL PROTECTION

Cost should not be a determining factor in considering measures to safeguard the legal rights of citizens. However, to insure that retarded persons in the Commonwealth enjoy equal protection under the law, a few relatively small but important costs must be met by the state.

Further study is needed to work out the details of the recommended program of legal assistance for the retarded. At a minimum, an effective program will require that a qualified attorney be available to persons residing in facilities for the retarded and to the families of retardates in the community. Initially, at least one full time attorney should be provided for each of the four regions. Salary and expenses are estimated at $60,000 per year.

Recommendations on the legal aspects of providing alternatives to institutionalization require financial support for additional staff in the Division of Child Guardianship. A total of eight social workers will be needed for the purpose of in-

creasing foster home placement for retardates and offering services to retarded wards after they reach the age of 21. Estimated annual cost is approximately $65,000.

Other cost factors include funding the various legal studies pertaining to civil rights of institutionalized persons, adult guardianship, and retarded juvenile offenders.

FINANCING PREVENTION

Delivery of health, education and social services to high risk populations and expansion of public health preventive programs will require financial support from a variety of sources. Since many prevention efforts are not limited to dealing with retardation alone, a variety of public and private agencies should be involved. In addition to state and local resources, federal funds should be utilized. Funds for retardation prevention programs are currently available from the Office of Economic Opportunity, the Office of Education, Public Health Service, National Institute of Mental Health, and the Children's Bureau.

The planned Maternity and Infant Care Project for Boston, which is designed to provide prenatal and maternal health services for high risk patients in Boston, presents an example of shared responsibility for financing prevention. Seventy-five percent of the total cost will be met by Children's Bureau funds, and the remainder will be covered by local resources. The state legislature has appropriated $150,000 to stimulate similar projects in other areas. This state commitment should be continued and expanded until adequate maternal and infant care is available in all parts of the Commonwealth.

Pilot programs and demonstration projects recommended to reduce the risk of retardation should also be financed under various auspices. Public and voluntary health and welfare agencies should contribute to the cost of operating the 10 recommended pilot preschool day care enrichment centers. Based on the experience of Head Start full year programs costing approximately $1,500 per child and an expected enrollment of 100 to 150 children, the total annual cost of operating 10 preschool enrichment centers will be approximately $1.8 million.

Increased staff and resources are needed for the Department of Public Health to continue efforts in the biomedical sphere to prevent retardation. Over-all expansion of the Department of Public Health Institutes of Laboratories should include an initial annual appropriation of $15,000 for continued research on detection of immunity to German measles, $12,000 to develop a vaccine against hemophilus influenzae, and $6,000 to initiate preliminary research on the lead poisoning problem. Current appropriations for research and testing for detection of metabolic disorders should be augmented to allow for an expanded program and to meet the cost of escalating salaries and hospital charges.

Other Department of Public Health staff requirements related to prevention of retardation include two additional radiation inspectors and a radiation physicist at an annual cost of $25,000. An inspector to enforce recent legislation on distribution of unsolicited drug samples at an estimated salary of $7,000 is also needed.

FINANCING RESEARCH

Each state department serving the retarded should support research in retardation at a minimum level equal to 4% of the department's direct service expenditures for the retarded. Based on expenditures for 1965, the minimum annual retardation research appropriation for each department would be as follows:

Department of Mental Health	$1,008,822
Department of Education	179,116
Department of Public Welfare	172,818
Department of Correction	80,969
Division of Youth Service	29,171
Massachusetts Rehabilitation Commission	9,918
Division of Employment Security	(not available)

The 4% guide does not apply to the Department of Public Health. Research activities presently constitute a major portion of public health retardation programs. In fiscal 1965, the Institute of Laboratories, which conducts a great deal of research related to retardation, expended more than $1 million. Research activities of the Department should continue to expand regardless of the level of direct service expenditures.

Taking into account the Department of Public Health research expenditures and the anticipated rise in direct service budgets, state expenditures for retardation research should be well in excess of $2 million in fiscal 1968 and more than $3 million in 1976.

In addition to the research funds of the departments, $50,000 should be appropriated to establish a state retardation research fund to provide "seed money" and to encourage preliminary research efforts.

APPENDIX A

A SHORT HISTORY OF PRIVATE AND PUBLIC RESPONSE TO RETARDATION IN MASSACHUSETTS

HISTORICAL DEPRIVATION OF RETARDED PERSONS

Most of the Christian sects of the early 1800's felt that retarded persons were possessed of the devil or that retardation was the result of sinful behavior. With the exception of a few enlightened medical pioneers, leaders in medicine agreed that it was their public duty to relieve families of "unbearable burdens." Popular religious beliefs allowed for public sanctioning of a policy of isolation. A lack of medical knowledge about retardation reenforced this policy by a practice of separating retarded children from their parents. Families in the communities of the Commonwealth practiced the belief that their retarded family members should be "out of sight", and hopefully, "out of mind." Disabled children were hidden in attic rooms. Many early immigrants who were unable to find jobs or speak English were thought to be retarded and were placed in jails, alms houses, and on county poor farms. Mysticism and fears born out of collective social ignorance reduced the retarded person to a less than human existence.

A pronounced religious zeal for perfection in mind, spirit, and body exemplified in many of New England's traditions was not equaled by a zeal for compassion and understanding of individuals less able to achieve these early standards of perfection. This paradox in social behavior toward the less capable still presents the basis for some of the social drag in the development of new programs for retarded persons. Clearly, history shows that the retarded person became the object of extreme methods of social controls, whether he was relegated to the filth and abuse of the county jail in the nineteenth century, or to the humiliating environment of the overcrowded, understaffed, locked ward of the twentieth century.

With the exception of some pioneering studies of cretinism and mongolism, medicine viewed idiocy as a hopeless medical condition. As a consequence of this hopeless attitude over the years, the retarded person suffered from the lack of beneficial legislation to improve his place in society. Legislation that was enacted for the retarded, continued to assure a policy of social isolation, medical and professional aloofness from this condition, and the deprivation of most of their constitutional rights as citizens.

EMERGING SOCIAL AWARENESS

In the first half of the nineteenth century, Massachusetts was fortunate to have in its midst certain individuals possessing social awareness, human concern, and an unusually impressive grasp of the educational potential of retarded persons. These key individuals represented a variety of influences for social betterment. Dr. Samuel Gridley Howe, a graduate of Harvard Medical School, brought a dimension of medical knowledge to the problems associated with educating deaf mutes, blind, and feeble minded children. George Sumner and his brother, Senator Charles Sumner, brought to Boston a knowledge of the work of Edouard Sequin's outstanding accomplishments with feeble minded children in France. Both brothers were influential in improving the lot of retarded persons through the political system of Massachusetts. Horace Mann, a close friend of Dr. Howe, worked with individual school committees in the towns to upgrade educational methods. Dorothea Lynde Dix, the nationally and internationally famous crusader on behalf of the insane, gathered figures on the number of retarded persons and the conditions under which they were subjected. Miss Dix was a close friend and associate of Dr. Howe. As a consequence of his association with Miss Dix and Colonel Thomas A. Perkins, Dr. Howe reached national and international prominence concerning his methods for the education of retarded children.

Early efforts of these key individuals to identify the idiots and feeble minded of the community set in motion an atmosphere of public alarm. Writers talked of the social menace of feeble minded persons and how the multiplication of children of these families "threatened to overwhelm the civilizations of the future." There was minimal legislative interest in providing adequate facilities and equipment.

PUBLIC ATTITUDES AND POSITIVE SOCIAL ACTION

The low ebb in public attitudes toward retarded persons came between the period of 1910–1945, spurred on by emotionally charged exhortations. With several heredity studies in hand, some eugenicists came forth warning that unless something drastic was done, the feeble minded would overrun the world. Publically sanctioned purging of retarded persons took place in Germany between 1930–1945. Not far behind, various legal procedures were adopted denying basic human rights throughout many countries and states, including Massachusetts. Sterilization laws were instituted in many states due to acquiescence and lack of insight by the political leaders, medical leaders, and the public. Massachusetts never instituted such a law, but it promoted other laws which allowed for lifetime incarceration of retarded persons without the legal safeguards enjoyed by the majority of people in our society.

Dr. Leo Kanner pointed out in his *History of the Mentally Retarded*,

> "It did not seem to occur . . . to the preachers of gloom that civilization was indeed in grave danger, but that the danger did not come from mental defectives."

Scapegoating and the advocacy of blind supremacy of superman over subman was a product of a society's ignorance combined with the worst in social fanatacism.

On the positive side, in 1915, a new piece of evidence concerning the potential of retarded persons was introduced into the mainstream of social policy. A follow up study in Massachusetts of patients who had been discharged or had run away from state schools over a period of 25 years revealed that many of these persons had become self supporting with little or no supervision. Many of the retarded persons surveyed were living at home without causing any trouble, even if unable to support themselves. This was a startling discovery. This finding dispelled the medical and popular opinion that the retarded could not function outside the institution.

Findings of this study were influential in the development of a law which allowed for the boarding out of retarded

persons who, otherwise, would have been permanently kept in state institutions.

In 1940, mothers of ten trainable children living in Boston joined together and got Mrs. Grace Raynes, a teacher psychologist from the Department of Mental Health, to work with their children. This group formed the Child Betterment Association, and initially held meetings in the different mothers' homes. This group eventually moved its work to the Boston Street Health Unit. This initial group of ten mothers continued for about five years until 1945, when they decided to increase their membership, and together work to get their children into the school system, and in other ways improve the welfare of retarded children. Other parents became interested, and eventually as the group of parents became larger, they formed the Boston Association for Retarded Children in 1945.

The Boston Association for Retarded Children was the first group of its kind to be established in Massachusetts. Rapidly, the movement spread to other sections of the state with the assistance of the Boston chapter and the newly developed state association. More than 24 local organizations joined together and incorporated as the Massachusetts Association for Retarded Children in 1952. By 1957 more than 5,000 members, including parents, professionals, and interested laymen, formed a strong public voice for the needs of retarded persons in Massachusetts. In 1950, the state association became an active participant in the National Association for Retarded Children formed that year.

Reasons that contributed to the growth of parent interest are based on several factors. Institutions operating with inadequate public appropriations were severely limited in what they could do for retarded children. Usual public school programs were unsuited for many retarded children; where they did exist appropriate educational programs and materials were lacking.

Greater public understanding concerning child development created a new impetus for improved programs. Both lay and professional people were challenging the validity of the concept that retardation was always a chronic condition. Parents themselves were seeking to learn more about what they could do for their own children. Projects for the betterment of all retarded children were instituted. Parents were convinced that the widespread incidence of retardation among all segments of the population represented a social responsibility on the part of all. Physically handicapped children had been the beneficiaries of public fund raising. It was felt that retarded children should also have equal opportunity for realizing their potential, and that, consequently, public contributions should be solicited for that purpose.

Local associations have been responsible for many demonstration projects in Massachusetts including parent efforts for public education, the development of recreational programs, preschool nurseries, volunteer services, vocational training, and educational reform. The work of the state association was greatly assisted by the creation, in 1952, of the special commission established to make an Investigation and Study Relative to Training Facilities Available for Retarded Children.

In a hearing before the Committee on Public Welfare of the Massachusetts legislature in 1954, the effects of this organized movement in the state were impressive. Two-thirds of both branches of the General Court appeared personally, and advocated passage of pending legislation. The hearing room was crowded with about 400 people from all over the state, representing parents, professionals, and interested friends of retarded persons. As one senator remarked, "This was an amazing development."

A more enlightened public attitude toward the retarded appeared as a consequence of the gradual development of special classes in the public schools and the creation of preschool nurseries.

In the report of the Special Commission on Mental Retardation of 1953, social, economic, and educational changes in American thinking since World War I were noted as reasons for fresh approaches to chronic social problems. Early discovery of retardation was possible through improved techniques. The rapid increase in population and a longer life span for individuals called for expansion and reconstruction of services. Compulsory school attendance laws and the rapid growth of urban centers called for new approaches to educational and vocational training. Due to more lucrative war time employment, and a consequential lack of trained people, a reevaluation of the staffing patterns of state institutions was needed. Federal leadership in White House Conferences emphasized the social value of retarded children remaining in their homes, and showed that institutional care was often detrimental in their development. Parent organizations demanded equal opportunity for mentally handicapped children in educational programs. Attitudes held by the whole community, as well as the inertia of helping professions, were challenged. Religious and social values became more humanitarian as the economic potential of the retarded was demonstrated. With the establishment of the World Health Organization of the United Nations, greater international communication was initiated between professional and lay leadership interested in disabled populations in every country. Spokesmen for the affluent society began to turn their sights on the unfinished business of the twentieth century.

On October 17, 1961, the President of the United States, John Fitzgerald Kennedy, appointed a panel of experts with a mandate to prepare, before December 1962, a national plan to combat mental retardation. Legislation which emerged from the report was presented to Congress in a special presidential message in January 1963.

Massachusetts made several contributions to the findings of the President's Panel. Three of its subcommittees were served by representatives of the Massachusetts Department of Mental Health and the Special Commission on Mental Retardation. A report on special education in Massachusetts was submitted to a regional meeting of the President's Panel in Providence, Rhode Island. The report of the Panel also included findings which first appeared in the reports of the Special Commission on Retardation to the Massachusetts legislature. P.L. 88–156 of the 88th Congress formed the basis for implementing a national plan to combat retardation. Supported by that legislation and by public officials and concerned citizens throughout Massachusetts, the Massachusetts Mental Retardation Planning Project prepared this report.

PROGRAMS AND FACILITIES FOR RETARDED PERSONS IN MASSACHUSETTS (1800-1965)

FIRST LEGISLATIVE ACTION

Prior to the nineteenth century, there was no public or private facility for the care of retarded children on the North American continent. As late as 1800, retarded persons in Massachusetts were cared for in their homes, on town or county poor farms, in asylums for the blind, deaf, and insane, in jails, and prisons.

On January 22, 1846, the Massachusetts legislature appointed the first commission to consider the needs of the retarded based on a resolution by Judge Bymington. On the 11th of April, 1846, commissioners were appointed " . . . to inquire into the condition of the idiots of the Commonwealth to ascertain their number and whether anything can be done in their behalf."

FIRST PUBLIC SCHOOL FOR RETARDED CHILDREN

As a result of the legislative commission's action, an appropriation of $2,500 was made in 1848 for the establishment of an experimental school for the retarded in conjunction with Perkin's School for the Blind. The appropriation was made with the understanding that a number of private pupils would be added to help bear expenses.

A building in South Boston, formerly a resort hotel on Boston Harbor, housed the school for the blind. Here, at the old site of the Perkins School for the Blind, the first experimental school for "ten idiotic children" utilizing public funds began in Massachusetts.

FIRST PRIVATE SCHOOL

Later in 1848, Dr. Harvey Wilbur of Barre, Massachusetts, started the first private school for retarded children in the United States. His work was so successful that he was called to New York State where he remained as superintendent of a school for the retarded at Syracuse for 29 years. Dr. Wilbur was one of the founding fathers of the American Association on Mental Deficiency in 1876.

FIRST STATE CONSTRUCTION APPROPRIATION

In 1850, two years after the first public appropriation for the experimental school, a group of influential citizens formed a corporation for the purpose of establishing the Massachusetts School for Idiotic and Feebleminded Youth. In 1856, the legislature voted $25,000 for a new building and grounds on condition that friends of the school raise $5,000 for furnishings. The new building was opened in 1857 with a capacity for 90 children. An initial appropriation of $7,000 for the care of 45 patients was made.

Historians of the period between 1850 and 1900 point out that there was a constant struggle to overcome the indifference of the Massachusetts legislature towards the needs of retarded persons. Whereas Massachusetts was the first state to make any public provisions, other states, notably New York, Pennsylvania, and Ohio, later advanced much faster with better facilities for more persons in need of care.

By 1865, 14 years after the Massachusetts School for Idiotic and Feebleminded Youth started, there were only 65 pupils in the school. Although there were many applications for admissions, " . . . niggardly legislative appropriations prevented expansion."

The Massachusetts School for Idiotic and Feebleminded Children, later to be renamed the Walter E. Fernald State School, was the first partnership on behalf of the retarded between a private corporation and a public agency, the Department of Mental Diseases. Expanded residential care came much later in Massachusetts.

STATE RESPONSIBILITY FOR CARE AND TRAINING

The Act of 1851 finally resolved that the Commonwealth should pay for the care and training of "indigent and idiotic children belonging to this Commonwealth." An extension of the state's responsibility occurred in 1905, when the laws of the Commonwealth stated that the " . . . Commonwealth shall have the care, control, and treatment of all mentally ill, epileptic, and mentally deficient persons." This authority has rested solely with the Department of Mental Health to this day. As a result of this legislation, Wrentham State School was opened in 1907, Belchertown State School in 1929, and the Paul A. Dever State School, formerly the Myles Standish State School, in 1947.

SPECIAL CLASSES IN PUBLIC SCHOOLS

The first special class for retarded children in a public school system in Massachusetts began in Springfield in 1893. This was followed by a special class in Boston in 1899 and in Newton in 1905.

Chapter 71, Section 46 of the General Laws, was a milestone in the education of retarded children. With minor amendments, the original legislation governed public school education of retarded children until 1954. The law assured to every retarded child the right to attend public school provided that he could adjust to a classroom situation and that his presence was not detrimental to other members in his classroom. Special classes have been developed in most of the cities and towns of the Commonwealth. As of 1966, 60 towns and school systems still have no special class provision.

EARLY DIAGNOSTIC AND EVALUATIVE PROGRAMS

In 1919, legislative provisions were made for the establishment of free clinics for the mentally deficient. In cooperation with the Department of Education, the Department of Mental Health developed outpatient clinics all over the state for the "diagnosis of pupils who are three or more years retarded mentally." Pupils were assigned to special classes in the state in accordance with provisions of Chapter 71, Section 46, passed in that same year.

This 1919 law requiring diagnosis of retarded children was implemented by the outstanding efforts of Dr. Walter E. Fernald and his staff who prepared physicians, psychologists, and social workers to conduct traveling school clinics. Teams of qualified examiners were developed in the state schools and in all the state hospitals of Massachusetts between 1919 and 1934. Approximately 6,000 retarded children were examined annually in the public school system. Each year, the Harvard Summer School for Teachers of Special Classes was conducted for two weeks. In addition, the Harvard Graduate School of Education provided courses by Dr. Fernald and his staff for a period of 13 weeks each spring on the subject "Clinical Study of Mentally Deficient Children."

During the 1920's, a series of child guidance clinics were established in Worcester, East Boston, Lowell, Lawrence, Reading, Springfield, and at the Boston Dispensary.

In 1922, the Division of Mental Hygiene was formed by an act of the legislature within the then Department of Mental Diseases. This Division was responsible for developing knowledge about the cause and prevention of retardation and was empowered to establish, foster, and develop outpatient clinics. Chapter 123 was amended in 1955 to allow the Division to collaborate with other public and private agencies to provide cooperative and complementary outpatient facilities. In almost all instances in the state, local mental health associations, and local associations for retarded children became "partners" with the Division in providing local clinical services and preschool nursery programs. This private-public partnership arrangement has led to the proposed development of area citizen boards with representatives of both mental health and retardation to be involved in rendering and being responsible for direct mental health and retardation services. The historical development of this state and local, public and private administrative arrangement for the delivery of services formed the basis for the new Community Mental Health Act of 1966.

Over the years, child guidance clinics have grown in number and scope, resulting in a network of 36 clinics throughout the major population centers in the state. Most of these centers serve retarded children and a few serve retarded adults. Thirty-three preschool nursery clinics for retarded children are currently in operation within this state-local administrative arrangement.

In 1922, the Massachusetts legislature allowed the "boarding out" of retarded persons from the institutions to community homes for the first time.

SPECIAL COMMISSION ON MENTAL RETARDATION

In 1952, a Special Commission on Mental Retardation was created by the Massachusetts legislature. Its official title is "A Special Commission Established to Make an Investigation and Study Relative to Training Facilities for Retarded Children."

In 1953, this Special Commission emphasized the need for expanded vocational guidance and vocational training for retarded persons in Massachusetts. With the passage of P.L. 565 of the 83rd Congress, the Vocational Rehabilitation Act gave impetus to the establishment of rehabilitation centers and sheltered workshops. A vocational rehabilitation program had been in effect in Massachusetts since 1922 under the Department of Education. Federal support for services to the retarded was authorized through the Office of Vocational Rehabilitation as early as 1943. The Massachusetts Rehabilitation Commission was not created until 1956. Sheltered workshops in Massachusetts grew up sporadically under private auspices, with the exception of some vocational rehabilitation centers developed by the Department of Mental Health. Leadership for their creation has been shown principally by the Goodwill Industries, and the local chapters of the Massachusetts Association for Retarded Children. Some of these sheltered workshops have a fee for training arrangement with the Massachusetts Rehabilitation Commission for the retarded persons in the programs. The serious lack of sheltered and transitional workshops for retarded persons is a deep concern in present program development.

PRESCHOOL NURSERY CLINICS

In 1957, responsive to a recommendation from the Special Commission on Retardation, the Massachusetts legislature authorized the creation of 16 preschool nursery clinics to serve as diagnostic and training facilities in the community for retarded children of preschool age. The first clinics under this mandate were established by the Department of Mental Health in 1958.

Dr. Harry C. Solomon, Commissioner of the Department of Mental Health, in a communication to the Governor on November 6, 1959, recommended that " . . . one should add some 30 more facilities similar to those now in existence and from time to time, raise the age level of care." Dr. Solomon was referring to problems of the more severely retarded child who, after receiving training in the nursery clinics, is not yet ready for a special class in the public school, or is not in need of institutional care, but who does need special day care services.

DAY OCCUPATIONAL PROGRAMS

In 1959, the Special Commission on Mental Retardation inquired into the feasibility of implementing day occupational training programs in the four state schools. These day programs were to serve post school age retarded youth who were living in the community. Each of the four state schools has developed day occupational training programs with increasing emphases on vocational training, work evaluation, and work production. Local associations for retarded children have developed a number of day vocational training programs for post school age retarded persons.

MANPOWER NEEDS

Problems of recruiting and retaining all levels of professional and ancillary personnel were subjects of legislative concern in 1960. The Special Commission on Mental Retardation was critical of the salary schedule of all employees, and worked on the need for upgrading living quarters for employees in the state institutions for the retarded. In the area of professional understaffing, the Commission found a grave shortage of physicians. Almost no physicians trained in this country were accepting positions at the state schools. Applicants for the position of physician in the state schools were usually trained in other countries, and often were unable to speak English. The practice of these physicians was to stay in the state schools until they were sufficiently trained and oriented to pass the State Board of Registration examinations. The Commission pointed out that improvement of the care and treatment of all the retarded depended upon the interest which the various professional disciplines manifested in the problem of retardation as well as the attractiveness of salaries. As a result of this review, the Commission recommended university and hospital school affiliations for the four state schools as a way of attracting and holding staff members interested in teaching, research, and direct service.

COST OF CARE

For the first time, in 1960 the Special Commission on Mental Retardation tried to limit charges for the support of persons residing in schools for the retarded. The proposed act limited the cost to not more than $520 in any one year. It also proposed that charges for support should cease against any person resident in an institution who had reached the age of 21. An act was proposed that would establish a Board of Appeals that would review charges for such support. This Board of Appeals would have had representatives from the Department of Mental Health, the Massachusetts Association for Retarded Children, and a representative designated by the Governor. These acts failed to pass the legislature. However, each year, subsequent to 1960, a bill has been filed seeking to alter present policy regarding the cost of care.

COMMUNITY EVALUATION AND REHABILITATION CENTERS

An act to establish community evaluation and rehabilitation centers at the state schools, as well as a feasibility study for a central community evaluation rehabilitation center was passed in 1963. Appropriations for these centers have been made and a special report was completed in 1966 for the " . . . Establishment of a Central Community Evaluation-Rehabilitation Center for the Mentally Retarded."

NEW EDUCATIONAL TECHNIQUES

In 1963, at the request of the Department of Public Health, the Special Legislative Commission on Retarded Children instituted a study to evaluate the needs for the feasibility of " . . . Establishing a Closed Circuit TV System at the Massachusetts Hospital School in Canton" for the purpose of providing increased educational opportunities for handicapped children at the hospital school, for training of professional personnel, and for research into utilization of educational television for developing new techniques of instruction for handicapped children. This act was passed. The initial phase of this program is operative and highly successful.

CONSTRUCTION NEEDS

In 1964, the Commission undertook a thorough and careful study of physical conditions in the four state schools. In the Commission's report there is a harsh indictment of the Commonwealth for its inhumane neglect of retarded children in the state schools. The report states that the Commission members were appalled with the intolerable living conditions in many inadequate buildings.

As the report says:

> "With profound regret we report that Massachusetts, first in the nation to establish a residential school for the mentally retarded; first in the nation to institute compulsory public school education for educable and trainable retardates; first in the nation to inaugurate such community service programs as nursery clinics, recreational activities, and teacher training scholarships, has yet to emerge from the dark ages with regard to the quality of care offered to those unfortunate retarded individuals who require placement in a residential school." (H #3601, p. 9, paragraph 3).

Several reasons for the cause of this deplorable state of affairs were cited: the serious social and economic upheaval due to the depression in the 1930's; the drain of energy due to the two world wars; national and local preoccupation with the development of child guidance clinics; and programs which diverted public energy from the programs of state residential centers.

The Commission recommended the immediate capital outlay of $12,000,000 and an additional expenditure of $15,000,000 over the next five years to remedy the situation. Since the post war period a building program to meet the needs of the increased residential population had not developed. By 1964, the percent of overcrowding in the state schools ran as high as 20% in two of the state schools according to the standards of the American Association on Mental Deficiency. Moreover, there has been 30 years of drastic depreciation in existing structures.

STATEWIDE INVENTORY OF FACILITIES, PROGRAMS, AND SERVICES

A statewide inventory of specialized and general services to retarded persons was conducted by the Department of Mental Health and the Massachusetts Mental Retardation Planning Project in 1965. Nearly 600 agencies were surveyed. Results of this inventory provided the basis for the Massachusetts state plan for the construction of mental retardation facilities.

STATE SCHOOLS

Although the community was providing for the education and training of the retarded, the Special Commission on Mental Retardation noted in 1953 that there was still a relatively large group of retarded persons with emotional and other defects not adequately served. Community adjustment was difficult for these individuals and they required at least temporary care in an institutional setting. A change in the character of the patient population occurred with a substantial increase in the number of severely and profoundly retarded under the age of 5 years in state schools. This change placed new demands on patterns of staffing. In many institutions, the Commission noted ward coverages were at a dangerously low level. It was not uncommon to find one person on night duty in a dormitory containing more than 100 boys and girls.

To solve the problem of institutional service direction, the Commission proposed five directors of service to assist the superintendents of the state schools: a Director of Research; a Director of Physical Education, Recreation, and Athletics; a Director of Industrial Training; a Director of Volunteer Services; and a Director of Family Life. Interestingly, a Director of Research was advocated only for Fernald and Wrentham State Schools. In retrospect, this has proven to be an unfortunate oversight, since the other state schools could also have profited from research programs. This attempt to reorganize principal services at the state schools was, in small part, adopted. However, an individualized approach to the retarded person has been implemented on a minimal basis.

COORDINATION

In 1955, for the first time in Massachusetts, the problem of retardation was stated in new strategic terms by the Special Commission on Mental Retardation. The Commission saw the problem as a concern for the community, and as cutting across agency lines. Here, for the first time, a recommendation was made for the establishment of a permanent board under the Governor whose function would be to coordinate the various departments, agencies, and personnel concerned with any phase of the care and treatment of the handicapped. Greater emphasis was placed on coordination and collaboration for the purpose of planning. The problem of retardation was defined as an interdepartmental responsibility, but no solution was advocated.

In 1956, the Special Commission on Retardation made a strong recommendation for research at the state level, as well as the development of federal and state matching programs. The Commission drew attention to the increasing amount of national legislation designed to aid state programs on a matching basis, especially for training personnel, better diagnostic facilities, vocational rehabilitation, and improved educational techniques. The Commission stated:

> "Massachusetts is not availing itself of the opportunity to obtain these federal funds. Therefore, we recommend that research programs at the state level be initiated by a Coordinating Board composed of the Commissioners of the Departments of Mental Health, Public Health, Education, Welfare, Labor and Industries or their respective representatives."

Membership of the Committee would have been augmented by the appointment of four citizens selected by the Governor

with the advice and consent of the Governor's Council. The act which grew out of this proposal called, "An Act Establishing a Coordinating Committee Relative to Mentally Handicapped Children," did not receive the support of the commissioners of the relevant departments and the bill failed to pass the legislature.

In 1958, the Special Commission reported that to accomplish its aims, an intensive investigation was necessary of the programs in the various public departments in the state concerned with the care and treatment of the retarded. A growing recognition of the necessity for redefining interdepartmental responsibilities was approached, but never implemented.

In the Commission's report of March 1962, an effort was again made to establish an Interdepartmental Coordinating Committee on Mental Retardation. The act stated:

> " . . . said Committee shall function in an advisory and consultative capacity with the general objective of coordinating within the several departments of the Commonwealth programs designed to meet the problems of mentally retarded children and their families, and may promote, assist, and coordinate activities to meet such problems at the community level."

This act also failed to pass the legislature.

Although there was a failure to achieve the recommended administrative overhaul, partial measures were enacted by appointments of assistant commissioners in the Department of Education and in the Department of Mental Health by an act of 1963. Both positions were evolved for purposes of greater coordination and development of programs for mentally handicapped children in state institutions and in local community programs.

History shows that the state failed to provide appropriate administrative structures with adequate state appropriations over the years to meet local needs and demands for adequate services. Undoubtedly, this led to the necessity for federal direction in planning, and partial federal funding of new construction and staffing of local facilities.

To make proper use of federal funds for retardation now available and to coordinate the use of these funds with other state services for the retarded, the need for a permanent interdepartmental office assumes the utmost urgency.

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APPENDIX B

Massachusetts Population and Age Composition by Retardation Areas

Retardation Areas by Region	1960 Population	1970 Projection	1960 Median Age	Age Composition (1960) Under 5		5–14		15–24		25–54		55–64		65 and Over	
				No.	Rate[1]	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
Central Region															
Boston University	158,065	158,065	34.1	15,331	9,699	22,927	14,505	22,868	14,467	59,154	37,424	17,434	11,030	20,351	12,875
Brookline-Brighton	205,992	202,948	36.0	15,808	7,674	25,330	12,297	34,834	16,910	73,932	35,891	26,943	13,080	29,145	14,149
Government Center	185,180	181,048	32.8	17,488	9,444	30,193	16,305	26,126	14,108	71,953	38,856	18,414	9,944	21,006	11,344
Grafton	83,438	85,824	31.7	9,068	10,868	16,144	19,348	9,336	11,189	32,167	38,552	8,028	9,622	8,695	10,421
Medfield	157,507	209,000	29.5	19,347	12,283	33,102	21,016	16,834	10,688	62,220	39,503	12,663	8,040	13,360	8,482
Newton	126,716	133,500	31.6	10,855	8,566	23,920	18,877	18,318	14,456	46,885	37,000	13,781	10,876	12,957	10,225
Roslindale	230,187	230,187	33.5	23,060	10,018	38,629	16,728	29,290	12,724	85,068	36,964	26,508	11,516	27,614	11,996
South Shore	251,417	296,000	30.4	28,603	11,377	50,793	20,203	29,000	11,535	94,846	37,725	23,248	9,247	23,927	9,517
Tufts	57,557	57,557	29.4	6,832	11,870	11,243	19,534	7,777	13,512	20,169	35,042	5,115	8,887	6,421	11,156
Westborough	167,974	232,800	29.1	22,902	13,634	34,881	20,766	17,086	10,172	66,010	39,298	12,433	7,402	14,662	8,729
Northern Region															
Beaverbrook	123,220	129,000	32.8	12,936	10,498	20,694	16,794	15,856	12,868	46,917	38,075	13,455	10,911	13,362	10,844
Cambridge	202,413	188,000	31.3	19,823	9,793	29,175	14,413	36,453	18,009	73,670	36,396	20,433	10,095	22,859	11,293
Concord	37,868	51,500	28.9	5,030	13,283	7,982	21,078	3,935	10,391	14,917	39,392	2,725	7,196	3,279	8,659
Danvers	208,442	243,200	31.9	23,220	11,140	39,293	18,851	22,904	10,988	80,329	38,538	19,328	9,273	23,368	11,211
Haverhill	93,760	99,600	33.2	9,876	10,533	17,157	18,299	10,584	11,288	33,951	36,211	9,516	10,149	12,676	13,520
Lawrence	125,833	130,000	33.8	12,252	9,737	22,788	18,110	13,966	11,099	47,890	38,058	13,045	10,367	15,892	12,629
Lowell	177,542	215,800	29.5	21,990	12,386	35,946	20,246	20,906	11,775	66,311	37,349	14,945	8,418	17,444	9,825
Lynn	140,796	148,500	27.4	14,295	10,153	25,799	18,327	15,961	11,336	53,296	37,853	14,422	10,243	17,023	12,090
Malden	166,191	158,000	32.9	16,535	9,949	28,165	16,947	21,912	13,185	62,652	37,699	17,923	10,785	19,004	11,435
Mystic Valley	152,055	195,500	30.9	18,802	12,365	29,488	19,393	16,017	10,534	59,774	39,311	13,942	9,169	14,032	9,228
Reading	99,325	116,500	31.0	11,294	11,370	20,169	20,306	10,772	10,845	37,919	38,177	9,125	9,187	10,046	10,114
Southern Region															
Barnstable	95,067	105,447	31.6	11,167	11,746	16,833	17,706	12,117	12,746	33,657	35,403	8,981	9,447	12,312	12,951
Brockton	185,410	235,500	30.1	23,129	12,475	36,527	19,701	21,218	11,444	69,716	37,601	15,168	8,181	19,652	10,599
Fall River	131,734	139,486	33.1	12,518	9,502	23,560	17,884	16,175	12,279	50,905	38,642	13,882	10,538	14,613	11,093
Foxborough	66,622	82,500	30.4	7,660	11,498	12,864	19,309	8,263	12,403	24,692	37,063	5,785	8,683	7,358	11,044
New Bedford	138,803	146,119	34.4	12,928	9,314	24,105	17,366	15,681	11,297	53,065	38,230	15,121	10,894	17,903	12,898
Plymouth	37,911	50,653	32.4	3,981	10,501	7,309	19,279	4,233	11,166	13,915	36,704	3,730	9,839	4,743	12,511
Taunton	78,286	88,857	31.9	8,247	10,534	14,563	18,602	9,520	12,161	29,733	37,980	7,496	9,575	8,727	11,148
Western Region															
Berkshire	142,135	155,324	31.8	15,446	10,867	27,011	19,004	16,478	11,593	53,607	37,716	13,553	9,535	16,040	11,285
Fitchburg	148,623	168,679	28.3	17,185	11,563	27,408	18,441	23,706	15,950	54,106	36,405	11,711	7,880	14,227	9,572
Franklin	54,864	61,585	32.5	5,653	10,304	11,019	20,084	5,743	10,468	19,977	36,412	5,181	9,443	7,291	13,289
Gardner	45,885	51,083	33.1	4,651	10,136	8,534	18,598	5,148	11,219	17,048	37,154	4,623	10,075	5,881	12,817
Holyoke	153,123	168,927	30.4	16,609	10,847	28,630	18,697	20,720	13,532	58,150	37,976	13,751	8,904	15,263	9,968
Northampton	55,439	61,578	28.9	4,680	8,442	8,444	15,231	12,136	21,891	18,558	33,475	5,192	9,365	6,429	11,597
Southbridge	100,679	119,392	31.8	10,372	10,302	19,246	19,116	11,831	11,751	39,332	39,067	9,136	9,074	10,762	10,689
Springfield	296,799	326,838	31.5	33,412	11,257	56,907	19,174	33,555	11,306	114,212	38,481	27,315	9,203	31,398	10,579
Worcester	257,307	291,057	32.9	25,555	9,932	45,374	17,634	32,639	12,685	95,683	37,186	26,494	10,297	31,562	12,266
Totals	5,140,186	5,715,554	31.8	548,540	10,672	932,452	18,140	650,961	12,664	1,936,404	37,672	500,545	9,738	571,284	11,114

[1]Per 100,000 population. (Data based upon 1960 U. S. Census Report).

APPENDIX C

Indicators of Need by Retardation Area

Retardation Areas by Region	Socioeconomic Need Indicators				Specialized Retardation Need Indicators			
	Family Income Less Than $3,000[1]	Less Than 5 Years Education[2]	AFDC Recipients[3]	Deteriorating and Dilapidated Housing[4]	Admissions to State Residential Schools[5]	Waiting Lists for State Residential Schools[5]	Waiting Lists for Preschool Programs[5]	Special Class Public School Enrollment[6]
Central Region								
Boston University	25.6	8,696	5,465	33.8	12.3	13.3	6.5	113.4
Brookline-Brighton	13.0	3,931	2,755	10.2	4.9	7.3		40.9
Government Center	17.0	11,110	11,595	19.1	3.4	8.2		68.8
Grafton	10.9	5,962	517	12.7*	9.6	6.7	2.2	47.1
Medfield	6.6	5,280	220	7.8	9.8	5.5	1.0	37.7
Newton	5.8	2,931	118	4.1	9.6	7.8	**	37.1
Roslindale	10.3	6,510	2,200	8.4	17.6	12.3	6.9	51.2
South Shore	7.8	6,003	521	8.2	8.0	4.9	8.7	51.5
Tufts	22.1	9,929	4,258	27.3	11.6	10.5	**	115.3
Westborough	7.8	3,027	391	8.1	9.8	5.4		41.1
Northern Region								
Beaverbrook	7.7	4,521	461	4.6	10.5	7.4	2.3	53.3
Cambridge	12.2	6,012	1,466	13.8	9.2	8.0	7.6	45.4
Concord	7.5	4,584	428	8.0*	10.0	9.2		17.1
Danvers	11.4	4,634	777	12.3	9.4	5.8	4.3	40.9
Haverhill	13.6	4,937	1,014	20.4*	9.8	10.0	3.0	54.0
Lawrence	15.1	8,601	768	15.8	10.6	9.1	3.3	62.4
Lowell	9.0	4,892	955	21.9	8.5	6.2	2.3	49.5
Lynn	12.4	4,876	1,343	12.6	9.6	8.5	2.1	67.3
Malden	10.0	6,060	1,574	9.8	11.9	9.6	24.2	37.4
Mystic Valley	6.2	2,585	437	4.6	10.3	8.5	1.6	30.2
Reading	7.1	1,872	332	7.0	8.1	7.3	0.9	38.1
Southern Region								
Barnstable	18.8	3,427	1,066	10.5*	10.1	8.6	10.7	61.6
Brockton	10.3	4,617	920	11.3	10.6	6.4	10.8	65.9
Fall River	18.4	11,627	1,348	14.5	7.7	5.8	16.0	90.1
Foxborough	8.8	3,367	537	12.2*	10.1	9.3		67.7
New Bedford	20.4	12,728	1,764	12.1	8.5	6.5	10.8	102.1
Plymouth	14.5	4,909	1,029	15.9*	5.8	9.7	**	77.9
Taunton	14.4	6,637	884	13.0*	9.3	4.4		69.6
Western Region								
Berkshire	13.7	5,025	1,083	17.1*	9.3	0.7	3.9	35.6
Fitchburg	12.8	4,947	675	19.3*	8.1	5.2		52.9
Franklin	16.5	4,176	1,146	13.7*	12.9	2.4		93.7
Gardner	15.0	6,929	684	13.9*	12.5	2.3	**	96.4
Holyoke	12.2	6,194	616	8.6*	8.5	1.5	10.2	44.3
Northampton	15.1	7,356	386	13.7*	8.3	1.5		24.1
Southbridge	11.7	6,507	723	10.6*	10.6	1.4	**	39.3
Springfield	12.2	6,266	1,208	15.4*	7.0	1.9	6.9	83.3
Worcester	13.0	6,205	1,229	13.8	8.2	5.4		56.8

[1]Percent of total families.
[2]Rate per 100,000 population 25 and over.
[3]Rate per 100,000 population.
[4]Percent of total housing units.
[5]Rate per 100,000 population under 25.
[6]Rate per 100,000 eligible child population.
*Information not available for some towns in area.
**No nursery schools reported in area.

Sources: 1960 U. S. Census Report.
Massachusetts Mental Retardation Planning Project, Inventory of Facilities, Programs and Services, 1965–1966.

APPENDIX D

Rankings of Retardation Resources and Need Indicators by Area

Retardation Areas by Region	Ranking by Resources*					Ranking by Resources Available*	Ranking by Socioeconomic Need Indicators**				Ranking by Specialized Need Indicators**				Ranking by Composite Need**
	Diagnosis and Evaluation Programs	Preschool Programs	School Programs	Post School Programs	Generic Programs	Average of Resources in All Categories	Family Income Less than $3,000	Less Than 5 Years Education	AFDC Recipients	Deteriorating and Dilapidated Housing	State Residential School Admissions	State Residential School Waiting List	Preschool Program Waiting List	Special Class Enrollment	Average of Need in All Categories
Central Region															
Boston University	5	4	5	4	5	4.6	1	5	1	1	4	1	16	2	2
Brookline-Brighton	3	3	2	5	5	3.6	15.5	31	3	26	36	17.5	32.5	27.5	28
Government Center	4	3	4	4X	5	4	6	3	6	6	37	13	32.5	10	9
Grafton	1	2	2	2	1	1.6	24	18	29	17.5	19	19	23	23	23.5
Medfield	2	5	1	3	2	2.6	35	19	36	33	16	25	26	31	34.5
Newton	2	1	1	2X	4	2	37	35	37	37	19	15	3	33	32.5
Roslindale	2	1	3	4X	2	2.4	25.5	10	4	29	1	2	14.5	21	7
South Shore	5	5	3	3	4	4	30.5	17	28	30	32	29	12	20	31
Tufts	2	1X	5	4	4	3.2	2	4	2	2	6	3	3	1	1
Westborough	3L	2	2	2	3	2.4	30.5	34	33	31	16	26.5	32.5	26	36
Northern Region															
Beaverbrook	3	3	3	5	2	3.2	32	29	30	35.5	10	16	21.5	18	29
Cambridge	5	2	2	5X	3	3.4	20	16	8	13.5	24	14	13	24	13
Concord	4L	5	1	4	3	3.4	33	28	32	32	13.5	8	32.5	37	32.5
Danvers	4	2	2	4	3	3	23	26	21	20	21	23.5	17	27.5	26
Haverhill	1L	2	3	1	2	1.8	14	22	17	4	16	4	20	17	10
Lawrence	4	5	4	5	5	4.6	8.5	6	22	9	8	9	19	14	4
Lowell	2	3	3	2	3	2.6	28	24	18	3	26	22	21.5	22	21
Lynn	5	4	4	3	4	4	18	25	10	19	19	11.5	24	12	15
Malden	3	3	1	3X	3	2.6	27	15	7	27	5	6	6	32	12
Mystic Valley	3	3	1	3X	2	2.4	36	36	31	35.5	11	11.5	25	35	34.5
Reading	5	4	1	5	4	3.8	34	37	35	34	30.5	17.5	27	30	37
Southern Region															
Barnstable	1	2	4	1	2	2	4	32	15	25	13.5	10	10	15	11
Brockton	5L	4	4	4	3	4	25.5	27	19	23	8	21	8.5	13	17
Fall River	2L	4	4	3	2	3	5	2	9	11	33	23.5	7	6	6
Foxborough	1L	4	4	3	2	2.8	29	33	27	21	12	7	32.5	11	23.5
New Bedford	2	5	5	2	3	3.4	3	1	5	22	26	20	8.5	3	3
Plymouth	1X	1X	5	1X	2	2	11	23	16	8	35	5	3	8	8
Taunton	5	1	4	1L	3	2.8	12	9	20	16	22.5	30	32.5	9	18
Western Region															
Berkshire	1	1	1	1	2	1.2	13	20	14	7	22.5	37	18	34	22
Fitchburg	4	2	3	2	4	3	17	21	25	5	30.5	28	32.5	19	25
Franklin	4L	4	5	2	4	3.8	7	30	13	17.5	2	31	32.5	5	14
Gardner	1	1X	5	1X	1	1.8	10	8	24	12	3	32	3	4	5
Holyoke	3	4	2	1X	3	2.6	20	14	26	28	26	34.5	11	25	27
Northampton	1X	3	1	1X	3	1.8	8.5	7	34	15	28	34.5	32.5	36	30
Southbridge	2L	1	2	1X	2	1.6	22	11	23	24	8	36	3	29	19
Springfield	2	2	5	5	2	3.2	20	12	12	10	34	33	14.5	7	16
Worcester	4	5	3	5	4	4.2	15.5	13	11	13.5	29	26.5	32.5	16	20

Note: Data for Specialized and Socioeconomic Need Indicators in Appendix C.

*The 37 areas are ranked on a 5 point scale ranging from 1 (least resources relative to other areas) to 5 (most resources).

**The 37 areas are ranked on a 37 point scale.

X Facility not within area.

L Limited services.

DEFINITIONS OF RESOURCE AND NEED INDICATORS

SOCIOECONOMIC NEED INDICATORS

Actual numbers have been rated on a basis of a 100,000 population.

Annual Family Income of Less than $3,000:

The actual number of families within the total population in an area with an annual income of less than $3,000.

Source: 1960 U. S. Census Reports.

Less Than Five Years of Education:

The actual number of people within an area over the age of 25 who have achieved less than a 5th grade level of education.

Source: 1960 U. S. Census Reports.

AFDC Recipients:

The actual number within an area of recipients of Aid to Families with Dependent Children.

Sources: 1963 Report of the Massachusetts Department of Public Welfare.
1964 Report of Boston Welfare Department.

Percentage of Total Housing Units Considered Deteriorating or Dilapidated:

"Deteriorating housing" represents housing requiring more repair than would be provided in the course of regular maintenance.

"Dilapidated housing" represents housing which does not provide safe and adequate shelter, and in its present condition, endangers the health, safety, or well-being of the occupants.

Source: 1960 U. S. Census Reports.

SERVICE NEED INDICATORS

State Residential School Admissions:

The number of people, by area, admitted to state residential schools for the retarded in fiscal 1965.

Source: Division of Mental Retardation, Massachusetts Department of Mental Health.

State Residential School Waiting List:

The number of people within an area on waiting lists for state residential schools for the retarded in fiscal 1965.

Source: Division of Medical Statistics and Research, Massachusetts Department of Mental Health.

Preschool Nursery Program Waiting List:

The number of retarded children between the ages of 3–6 by area on waiting lists of programs sponsored by the Division of Mental Hygiene, of the Department of Mental Health, in cooperation with local associations for retarded children in 1965. It also includes those children in 1965 waiting for preschool nursery programs which are independently sponsored by the local associations for retarded children. The original data included, in addition, a 10% projection of waiting list need for areas where no local preschool nursery program is available.

Source: Division of Mental Hygiene, Massachusetts Department of Mental Health.

Special Public School Class Enrollment:

The number of students within an area enrolled in both trainable and educable classes in the public school system in Massachusetts in 1965.

Source: Division of Special Education, Massachusetts Department of Education.

RESOURCE INDICATORS

Diagnosis and Evaluation Programs:

Coordinated medical, psychological and social services, supplemented where appropriate by nursing, educational, or vocational services, and carried out under the supervision of qualified diagnostic personnel.

Source: Massachusetts Retardation Planning Project Inventory of Specialized Programs for the Retarded, 1965.

Preschool Age Programs:

All programs appropriate to retarded children within a 0–5 year old age group.

Source: Massachusetts Retardation Planning Project Inventory of Specialized Programs for the Retarded, 1965.

School Age Programs:

All programs available to retarded children within a 6–18 year old age group.

Source: Massachusetts Retardation Planning Project Inventory of Specialized Programs for the Retarded, 1965.

Post School Age Programs:

All programs appropriate to retarded adults who are 19 years old and over.

Source: Massachusetts Retardation Planning Project Inventory of Specialized Programs for the Retarded, 1965.

Generic Programs:

Community Services, such as health, education, and welfare activities, available to everybody including the retarded of all ages.

Source: Massachusetts Retardation Planning Project Inventory of Generic Programs Serving the Retarded, 1965.

APPENDIX E

Retarded Served in Centers and Clinics of the Department of Mental Health by Area

Fiscal 1964–1965

Mental Health Center or Clinic	*City or Town*	*Region*	*Total Client Population*	*Retarded*	
				No.	*%*
Barnstable	Pocasset	Southern	107	1	0.9
Beaverbrook	Belmont	Northern	300	23	7.7
Berkshire	Pittsfield	Western	490	6	1.2
Boston City Hospital	Boston	Central	340	26	7.6
Brookline	Brookline	Central	167	30	18.0
Cambridge	Cambridge	Northern	400	20	5.0
Central Youth	Southbridge	Western	150	5	3.3
Dorchester	Dorchester	Central	300	40	13.3
Eastern Middlesex	Reading	Northern	300	40	13.3
Framingham	Framingham	Central	232	25	10.8
Franklin County	Greenfield	Western	160	24	15.0
Lawrence	Lawrence	Northern	543	82	15.1
Lowell	Lowell	Northern	274	60	21.9
Lynn	Lynn	Northern	500	25	5.0
Holyoke-Chicopee	Holyoke	Western	600	60	10.0
Judge Stone	Brockton	Southern	795	35	4.4
Malden	Malden	Northern	22		
Martha's Vineyard	Edgartown	Southern	118	2	1.7
Mystic Valley	Lexington	Northern	360	26	7.2
Newton	Newtonville	Central	51		
Norfolk	Norwood	Central	159		
North Central	Fitchburg	Western	500	95	19.0
North Shore	Salem	Northern	280	20	7.1
North Suffolk	East Boston	Central	344	31	9.0
Northeastern	Haverhill	Northern	102	16	15.7
Northern Berkshire	North Adams	Western	112	25	22.3
Somerville	Somerville	Northern	170	15	8.8
South Shore	Quincy	Central	677	192	28.4
Springfield	Springfield	Western	536	44	8.2
Walden	Concord	Northern	100	16	16.0
Westfield	Westfield	Western	63	3	4.8
Worcester	Worcester	Western	1,002	210	21.0
Total			10,254	1,197	
Percent of total client population who are retarded					11.7

Source: Massachusetts Mental Retardation Planning Project, Inventory of Facilities, Programs and Services, 1965–1966.

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